SilverScript®
P.O. Box 30006, Pittsburgh, PA 15222-0330

January 1, 2022 - December 31, 2022

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of TRS-Care Medicare Rx Employer PDP sponsored by TRS (TRS-Care Medicare Rx)

This booklet gives you the details about your Medicare prescription drug coverage from **January 1, 2022 - December 31, 2022**. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, TRS-Care Medicare Rx, is offered by SilverScript® Insurance Company. When this *Evidence of Coverage* says "we," "us," or "our," it means SilverScript Insurance Company. When it says "plan" or "our plan," it means TRS-Care Medicare Rx.

This document is available for free in Spanish.

Please contact Customer Care at 1-844-345-4577 for additional information. (TTY users should call 711.) Hours are 24 hours a day, 7 days a week.

This information is available in a different format, including braille, large print, and audio formats. Please call Customer Care if you need plan information in another format.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2023.

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

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

2022 Evidence of Coverage

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in TRS-Care Medicare Rx, which is a Medicare prescription drug plan

There are different types of Medicare plans. TRS-Care Medicare Rx is a Medicare prescription drug plan (PDP). Like all Medicare prescription drug plans, TRS-Care Medicare Rx is approved by Medicare and run by a private company.

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

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

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of TRS-Care Medicare Rx.

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

If you are confused or concerned or just have a question, please contact Customer Care (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for the months in which you are enrolled in TRS-Care Medicare Rx between January 1, 2022 and December 31, 2022.

Each year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of TRS-Care Medicare Rx after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- TRS has determined that you are eligible for this plan
- You are eligible for Medicare and are enrolled in a TRS-Care Medicare Advantage health plan. If you don't purchase and maintain Medicare Part B coverage by continuing to pay your Part B premium, you will lose your medical or prescription drug coverage through TRS-Care.
- You are a United States citizen or are lawfully present in the United States
- – *and* – You live in our geographic service area (Section 2.3 below describes our service area)

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

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. Our plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the prescription drug coverage you receive under your Medicare Part D coverage in Chapter 3.

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

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

Section 2.3 Here is the plan service area for TRS-Care Medicare Rx

Although Medicare is a Federal program, TRS-Care Medicare Rx is available only to individuals who live in our plan service area. To remain a member of our plan, you must live in the United States or its territories. Please note: If you use a Post Office Box, you will need to provide proof that you live in our service area.

If you plan to move out of the service area, please contact Customer Care (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or prescription drug plan that is available in your new location.

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

Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?

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

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

Please carry your card with you at all times, and remember to show your card when you get covered prescription drugs. If your plan membership card is damaged, lost, or stolen, call Customer Care right away, and we will send you a new card. (Phone numbers for Customer Care are printed on the back cover of this booklet.) You may need to use your existing medical card or your red, white, and blue Medicare card to get covered medical care and services.

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

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our 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. There may be changes to our network pharmacies for next year. You may use the online pharmacy locator tool at info.caremark.com/trscaremedicarerx or call Customer Care (phone numbers are printed on the back cover of this booklet) for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network. It can be found online at MyDocumentSource.MemberDoc.com.**

Section 3.3 *Formulary*: The plan's *List of Covered Drugs*

The plan has a *Formulary (List of Covered Drugs)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by TRS-Care Medicare Rx. The prescription drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the TRS-Care Medicare Rx Drug List. See Chapter 3 *(Using the plan's coverage for your Part D prescription drugs)* for more information about the *Formulary*.

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

We will provide you a copy of the Drug List. The Drug List we provide to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should contact Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can view your formulary online at **MyDocumentSource.MemberDoc.com** or call Customer Care (phone numbers are printed on the back cover of this booklet). We will also continue to update our online drug pricing tool as scheduled and provide other required information to reflect drug changes.

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

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB"). See Chapter 4 *(What you pay for your Part D prescription drugs)* for more information about the Part D EOB.

The *Part D Explanation of Benefits* tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefit is used. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 4 *(What you pay for your Part D prescription drugs)* gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

The *Part D Explanation of Benefits* is also available upon request. To get a copy of a previously mailed EOB, please contact Customer Care (phone numbers are printed on the back cover of this booklet).

You have the option to receive your Part D EOB electronically. It provides the same information in the same format as the paper EOB you receive today. To opt in to receive a paperless EOB, visit Caremark.com/startnow to register. You will receive an email notification when you have a new EOB to view. You can opt out at any time by contacting Customer Care.

SECTION 4 Your monthly premium for TRS-Care Medicare Rx

Section 4.1 How much is your plan premium?

Please contact TRS for more information about the premium for this plan.

In addition, you must continue to pay your Medicare Part B premium, unless your Part B premium is paid for you by Medicaid or another third party.

If you pay a premium, in some situations, your plan premium could be less

There are programs to help people with limited resources pay for their prescription drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. If you qualify, enrolling in a program might lower your monthly costs. Chapter 2, Section 7 tells more about these programs.

If you are *already enrolled* and getting help from one of these programs, the **information in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your prescription drug coverage. If you don't have this insert, please call Customer Care and ask for the "LIS Rider." (Phone numbers for Customer Care are printed on the back cover of this booklet.)

If you pay a premium, in some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed. Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare prescription drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

For these members, the Part D late enrollment penalty may be added to the plan's monthly premium. If applicable, their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

- If you are required to pay the Part D late enrollment penalty, the amount of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.
- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income above a certain amount on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. Chapter 1, Section 6 explains the IRMAA in further detail.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

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

The Part D late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your Initial Enrollment Period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the Part D late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

TRS has elected to pay for your Part D late enrollment penalty, if applicable. However, you may be responsible for paying your Part D late enrollment penalty in the future if your coverage is terminated, you enroll in another Medicare prescription drug plan, or TRS stops paying your Part D late enrollment penalty.

Section 5.2 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 prescription drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year. For 2022, this average premium amount is $33.37.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.37, which equals $4.67. This rounds to $4.70. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

- First, **the penalty may change each year** because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D prescription drug benefits, even if you change plans.

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

Section 5.3 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 prescription drug coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **"creditable drug coverage."** Please note:
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare prescription drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
    - For additional information about creditable coverage, please look in your *Medicare & You 2022* handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your Part D late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a Part D late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that Part D late enrollment penalty. Call Customer Care to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

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

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. The premium for this plan is already embedded in the TRS-Care premium that usually comes out of the TRS retiree's annuity check. However, some people pay an extra amount because of their yearly income. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you must pay an extra amount directly to the government for your Medicare Part D coverage.

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

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213, 7 a.m. to 7 p.m., Monday through Friday (ET). TTY users should call 1-800-325-0778.

Section 6.4 What happens if you do not pay the extra Part D amount?

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

SECTION 7 More information about your monthly premium

Section 7.1 Many members are required to pay other Medicare premiums

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

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as Part D-IRMAA. Part D-IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan. If you are disenrolled from the plan, you will lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not TRS-Care Medicare Rx**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213, 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

Your copy of the *Medicare & You 2022* handbook gives information about the Medicare premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of the *Medicare & You* handbook 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 the *Medicare & You 2022* handbook from the Medicare website (www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If your TRS-Care monthly plan premium changes for next year, TRS will notify you at least 15 days prior to January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover, if applicable. A member who loses his/her eligibility during the year will need to start paying his/her full monthly premium, if applicable. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up-to-date

Section 8.1 How to help make sure that we have accurate information about you

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

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

Let us know about these changes:

- Changes to your name, address, or phone number
- Changes in any other medical or prescription 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
- If your designated responsible party, such as a caregiver, changes

If any of this information changes, please let us know by calling Customer Care (phone numbers are printed on the back cover of this booklet).

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

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

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

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

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

These rules apply for employer or union group health plan coverage:

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

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

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

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

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

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 TRS-Care Medicare Rx contacts (how to contact us, including how to reach Customer Care)

How to contact Customer Care

For assistance with formulary, pharmacy network, claims, billing, or member ID card questions, please call or write to Customer Care. We will be happy to help you.

Customer Care – Contact Information	
CALL	1-844-345-4577 Calls to this number are free, 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-888-472-1129
WRITE	SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs covered under the Part D benefit included in your plan. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or making an appeal about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Coverage Decisions and Appeals for Part D Prescription Drugs – Contact Information	
CALL	1-844-345-4577 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-855-633-7673
WRITE	SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department P.O. Box 52000, MC 109 Phoenix, AZ 85072-2000

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

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

Complaints about Part D Prescription Drugs – Contact Information	
CALL	1-866-884-9478 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-724-741-4956
WRITE	SilverScript Insurance Company Prescription Drug Plans Grievance Department P.O. Box 14834 Lexington, KY 40512
MEDICARE WEBSITE	You can submit a complaint about TRS-Care Medicare Rx directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Payment Requests – Contact Information	
CALL	1-866-235-5660 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
WRITE	SilverScript Insurance Company Prescription Drug Plans Medicare Part D Paper Claim P.O. Box 52066 Phoenix, AZ 85072-2066

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

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

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

Medicare – Contact Information	
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: **Medicare Eligibility Tool:** Provides Medicare eligibility status information. **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about TRS-Care Medicare Rx. **Tell Medicare about your complaint:** You can submit a complaint about TRS-Care Medicare Rx directly to Medicare. To submit a complaint, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

A State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please see the Appendix at the end of this booklet to find the contact information for the SHIP in your state.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit *www.medicare.gov*
- Click on "**Forms, Help, and Resources**" on far right of menu on top
- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
  - Option #1: You can have a **live chat**
  - Option #2: You can click on any of the "**TOPICS**" in the menu on bottom
  - Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Please see the Appendix at the end of this booklet to find the contact information for the Quality Improvement Organization in your state.

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

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

SECTION 5 Social Security Administration (SSA)

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

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

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

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

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

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid Agency in your state using the contact information in the Appendix at the end of this booklet.

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

Medicare's "Extra Help" Program

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

Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

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

- 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

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

Documentation from the state or Social Security showing your low income subsidy level is the preferred evidence of your proper cost sharing level. Please fax your documentation to us at 1-866-552-6205. Please include a phone number where we can contact you. If you cannot provide the documentation and need assistance or would like additional information, contact Customer Care, 24 hours a day, 7 days a week, at 1-844-345-4577. TTY users should call 711.

- SilverScript Insurance Company will accept any of the following documents as evidence:
    - A copy of your Medicaid card, which includes your name and eligibility date during the period for which you believe you qualified for "Extra Help;"

  - Details of any call you made to verify your Medicaid status, including the date a verification call was made to the state Medicaid agency and the name, title, and telephone number of the state staff person who verified your Medicaid status during the discrepant period;
  - A copy of a state document that confirms your active Medicaid status during the discrepant period;
  - A print out from the state electronic enrollment file showing your Medicaid status during the discrepant period;
  - A screen-print from the state's Medicaid systems showing your Medicaid status during the discrepant period;
  - Other documentation provided by the state showing your Medicaid status during the discrepant period;
  - A letter from Social Security showing that the individual receives Supplemental Security Income (SSI); or
  - An "Important Information" letter from Social Security confirming that the beneficiary is "automatically eligible for 'Extra Help.'"
- For beneficiaries who are institutionalized and qualify for zero cost sharing, the following documents will be accepted as evidence of your proper cost sharing level:
  - A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
  - A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
  - 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 a month after June of the previous calendar year.
- 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 Care if you have questions (phone numbers are printed on the back cover of this booklet).

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov for more information.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Your plan includes additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs may be lower than the costs described here. Please go to Chapter 4, Section 6 for more information about your coverage during the Coverage Gap Stage.

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

State Pharmaceutical Assistance Programs

A State Pharmaceutical Assistance Program (SPAP) helps some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide prescription drug coverage to its members. Please see the Appendix at the end of this booklet to find the contact information for the SPAP in your state.

AIDS Drug Assistance Programs

An AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through your state's ADAP program. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status.

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

For information on eligibility criteria, covered prescription drugs, or how to enroll in the program, please call your state's ADAP program (the name and phone numbers for this organization are in the Appendix at the end of this booklet).

SECTION 8 How to contact the Railroad Retirement Board

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

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

Railroad Retirement Board – Contact Information	
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group separate from this plan sponsored by TRS, you may call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227) with questions related to your Medicare coverage under the different plan. TTY users should call 1-877-486-2048.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, other than TRS-Care Medicare Rx, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

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

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

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

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

Are you currently getting help to pay for your prescription drugs?

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

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D prescription drugs

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

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

- Medicare Part A covers prescription 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 prescription drugs. Part B prescription drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of prescription drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2022* handbook.) Your Part D prescription drugs are covered under our plan.

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

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

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

- In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies or through CVS Caremark Mail Service Pharmacy. See Section 2 of this chapter.
- Your prescription drugs on the plan's *Formulary (List of Covered Drugs)* (we call it the "Drug List" for short) are covered by the Medicare Part D portion of your benefit. See Section 3 of this chapter, *Your prescription drugs on the plan's "Drug List" are covered by the Medicare Part D portion of your benefit.*
    - **Please note:** The "Drug List" does not include any drugs covered by the additional coverage provided by TRS.
- Your prescription drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. See Section 3 of this chapter for more information about a medically accepted indication.

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

Section 2.1 Use a network pharmacy

You should fill your prescriptions at one of the plan's network pharmacies. See Section 2.5 of this chapter for information about when we would cover prescriptions filled at out-of-network pharmacies.

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (info.caremark.com/trscaremedicarerx), or call Customer Care (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies.

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

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

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

What if you need a specialized pharmacy?

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

- Pharmacies that supply prescription drugs for home infusion therapy.
- Pharmacies that supply prescription drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- 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 prescription drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

Section 2.3 Using the plan's mail-order services

For certain kinds of prescription drugs, you can use the plan's network mail-order services. Generally, the prescription drugs provided through mail order are prescription drugs that you take on a regular basis for a chronic or long-term medical condition. The prescription drugs that are not available through the plan's mail-order service are marked as **"NM" for not available at mail** in our Drug List. *There may be additional drugs that are not available at mail and not marked NM, including some hepatitis B medications, post-transplant medications, and oral medications used to treat HIV. For more information, you may contact Customer Care (phone numbers are printed on the back cover of this booklet).*

Our plan's mail-order service allows you to order **up to a 90-day supply**. Filling one 90-day supply with the CVS Caremark Mail Service Pharmacy can sometimes cost you less than three 31-day supplies of the same prescription drug.

To get order forms and information about filling your prescriptions by mail, contact Customer Care (phone numbers for Customer Care are printed on the back cover of this booklet). If you need to request a rush order because of a mail-order delay, you may contact Customer Care (phone numbers are printed on the back cover of this booklet) to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second day or next day delivery of your medications, you may request this from the Customer Care representative for an additional charge.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, **if you have used mail-order services with this plan in the past year**.

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

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please log on to your Caremark.com account or contact Customer Care (phone numbers are printed on the back cover of this booklet).

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

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please log on to your Caremark.com account or contact Customer Care (phone numbers are printed on the back cover of this booklet).

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show you should be close to running out of your drug. If you choose not to use our auto refill program, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please log on to your Caremark.com account or contact Customer Care (phone numbers are printed on the back cover of this booklet).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best way to contact you. Please call Customer Care to give us your preferred phone number.

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

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance prescription drugs. Some of these retail pharmacies may agree to accept a lower cost sharing amount for a long-term supply of maintenance prescription drugs. Other retail pharmacies may not agree to accept the lower cost sharing amounts for a long-term supply of maintenance prescription drugs. In this case, you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance prescription drugs. You can also call Customer Care for more information (phone numbers are printed on the back cover of this booklet).

2. For certain kinds of prescription drugs, you can use the plan's network **mail-order service.** The prescription drugs *not* available through the plan's mail-order service are marked as **"NM" for not available at mail** in our Drug List. Our plan's mail-order service allows you to order up to a 90-day supply. See Section 2.3 of this chapter for more information about using our mail-order services.

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

Your prescription may be covered in certain situations

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

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered prescription drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail-service pharmacy (including high-cost and unique prescription drugs).
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.
- The vaccine is administered in your doctor's office.

In these situations, **please check first with Customer Care** to see if there is a network pharmacy nearby. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?

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

If you must use an out-of-network pharmacy in these situations, we will reimburse you your total cost minus your cost share amount for the prescription drug. You must submit a paper claim in order to be reimbursed.

Please check first with Customer Care to see if there is a network pharmacy nearby. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

SECTION 3 Your prescription drugs on the plan's "Drug List" are covered by the Medicare Part D portion of your benefit

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

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

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

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

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

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- – *or* – Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The additional coverage provided by TRS covers certain prescription drugs not covered under Medicare Part D. Payments made for these prescription drugs will not count toward your initial coverage limit or total out-of-pocket costs. These prescription drugs are not subject to the appeals and exceptions process.

Please contact Customer Care for any questions regarding your additional benefit. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

The Drug List includes both brand name and generic prescription drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

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

These prescription drugs may be covered by the additional coverage provided by TRS. Please contact Customer Care to find out if your drug is covered.

Section 3.2 There are three "cost sharing tiers" for prescription drugs on the Drug List

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

Cost Sharing Tier 1: Generic

Cost Sharing Tier 2: Preferred Brand

Cost Sharing Tier 3: Non-Preferred Brand

To find out which cost sharing tier your prescription drug is in, look it up in the plan's Drug List.

The amount you pay for prescription drugs in each cost sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

Please note: TRS provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit. For more information about your share of the cost or which prescription drugs may or may not be covered, please call Customer Care. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

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

You have two ways to find out:

1. Check the most recent Drug List we provided for information on your drug coverage. (Please note: The Drug List we provide includes information for the covered prescription drugs that are most commonly used by our members. However, we may cover additional prescription drugs that are not included in the provided Drug List. If one of your prescription drugs is not listed on the Drug List, you should contact Customer Care to find out if we cover it.)
2. Call Customer Care to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some prescription drugs

Section 4.1 Why do some prescription drugs have restrictions?

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

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

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

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

Please note: TRS provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit. For more information about your share of the cost or which prescription drugs may or may not be covered, please call Customer Care. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

Section 4.2 What kinds of restrictions?

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

Restricting brand name prescription drugs when a generic version is available

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

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

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

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

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

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

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

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4 of this chapter, some of the prescription drugs covered by the plan have extra rules to restrict their use.
    - For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost sharing tier that makes your share of the cost more expensive than you think it should be. The plan puts each covered drug into one of three different cost sharing tiers. How much you pay for your prescription depends in part on which cost sharing tier your drug is in.

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

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

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

TRS is providing additional coverage to your Medicare Part D prescription drug plan. This prescription drug may be covered. For more information on your prescription drug coverage, please contact Customer Care. (Phone numbers are printed on the back cover of this booklet.)

If your drug is not on the Drug List or is restricted, here are things you can do:

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

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer on the plan's Drug List**.
- – or – The drug you have been taking is **now restricted in some way** (Section 4 of this chapter tells about restrictions).

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

- **For those members who are new or were in the plan last year:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a 31-day supply. If your prescription is written for fewer than 31 days, we will allow multiple fills to provide up to a maximum of a 31-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

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

- If you experience a change in your level of care, such as a move from a home to a long-term care setting, and need a drug that is not on our formulary (or if your ability to get your drugs is limited), we may cover a one-time temporary supply from a network pharmacy for up to 31 days, unless you have a prescription for fewer days. You should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

To ask for a temporary supply, call Customer Care (phone numbers are printed on the back cover of this booklet).

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

You can change to another prescription drug

TRS provides additional coverage for some prescription drugs not covered by TRS-Care Medicare Rx. If your drug is not covered, you may talk with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Care to ask for a list of covered prescription drugs that treat the same medical condition. This list can help your provider find a covered prescription drug that might work for you. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

You can ask for an exception

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

If you are a current member and a prescription drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your prescription drug for next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

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

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

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

You can change to another prescription drug

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

You can ask for an exception

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

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

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

TRS is providing additional coverage to your Medicare Part D prescription drug plan. The additional coverage may cover this medication. For more information on your coverage, please contact Customer Care. (Phone numbers are printed on the back cover of this booklet.)

Section 6.1 The Drug List can change during the year

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

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

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

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

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online drug pricing tool as scheduled to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Care for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your prescription drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost sharing tier or add new restrictions to the brand name drug or both)**
  - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost sharing tier or add new restrictions or both.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
  - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**
    - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.
    - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
    - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

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

If any of these changes happen for a prescription drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the prescription drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

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

The additional coverage provided by TRS covers certain prescription drugs not covered under Medicare Part D. Payments made for these prescription drugs will not count toward your initial coverage limit or total out-of-pocket costs. These prescription drugs are not subject to the appeals and exceptions process. Please contact Customer Care for any questions regarding your additional benefit.

Section 7.1 Types of prescription drugs we do not cover

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

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

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

- Our plan's Part D prescription drug coverage cannot cover a prescription drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a prescription drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the prescription drug other than those indicated on a prescription drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System. If the use is not supported by any of these references, then our plan cannot cover its "off-label use."

Also, by law, these categories of prescription drugs are not covered by Medicare prescription drug plans:

- 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
- 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

The additional coverage provided by TRS covers certain prescription drugs not covered under Medicare Part D. If included, this will be identified in Chapter 3, Section 3.1 of this document. The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.) Please contact Customer Care for any questions regarding your additional benefit. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

In addition, if you **receive "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the prescription drugs not normally covered. Please call Customer Care for more information. (Phone numbers for Customer Care are printed on the back cover of this booklet.) However, if you have prescription drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare prescription drug plan. Please contact your state Medicaid program to determine what prescription drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6 of this booklet.)

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

Section 8.1 Show your membership card

To fill your prescription, show your TRS-Care Medicare Rx plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. This includes any additional coverage provided by TRS. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

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

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

SECTION 9 Part D prescription drug coverage in special situations

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

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

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

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

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

Usually, a long-term care facility (LTC) (such as a nursing home) has its own pharmacy or a pharmacy that supplies prescription 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 isn't, or if you need more information, please contact Customer Care (phone numbers are printed on the back cover of this booklet).

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

If you need a prescription drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your prescription drug during the first 90 days of your membership. The total supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the prescription drug in smaller amounts at a time to prevent waste.)

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

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

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

TRS may provide additional coverage for prescription drugs that would normally be covered under Medicare Part B. For more information, please contact Customer Care.

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

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

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

Section 9.5 What if you're also getting prescription drug coverage from an employer or retiree group plan?

In addition to coverage in TRS-Care Medicare Rx sponsored by TRS, 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 our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about "creditable coverage":

If you currently have prescription drug coverage, other than your coverage in TRS-Care Medicare Rx sponsored by TRS, that group's benefits administrator should send you a notice each year that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for prescription drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage because you may need them later. If you enroll in a Medicare plan that includes Part D prescription drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your other employer or retiree group plan, you can get a copy from that employer or retiree group's benefits administrator or the employer or union.

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

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

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

SECTION 10 Programs on prescription drug safety and managing medications

Section 10.1 Programs to help members use prescription drugs safely

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

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

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

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

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)

- Limiting the amount of opioid or benzodiazepine medications we will cover for you

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

The DMP may not apply to you if you have certain medical conditions, such as cancer or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs.

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

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

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

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

CHAPTER 4

What you pay for your Part D prescription drugs

Chapter 4. What you pay for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. 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* about the costs for Part D prescription drugs may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Care and ask for the "LIS Rider." (Phone numbers for Customer Care are printed on the back cover of this booklet.)

SECTION 1 Introduction

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

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Original Medicare Part A or Part B, and other drugs are excluded from Medicare coverage by law. As a member of TRS-Care Medicare Rx, some Medicare Part D excluded drugs may be covered since your plan has additional drug coverage. Please refer back to Chapter 3 to find more information about the type of coverage you have with TRS.

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:

- **The plan's *Formulary (List of Covered Drugs).*** To keep things simple, we call this the "Drug List."
    - This Drug List tells which drugs are covered for you under the Medicare Part D portion of this plan.
    - It also tells which of the three "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 the Drug List, call Customer Care (phone numbers are printed on the back cover of this booklet).
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Pharmacy Directory.*** In most situations, you should use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you how you can use the plan's mail-order service to get certain types of drugs. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

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

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

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share. You have no deductible for TRS-Care Medicare Rx and begin coverage in the Initial Coverage Stage when you fill your first prescription of the year.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

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

Section 2.1 What are the drug payment stages for TRS-Care Medicare Rx members?

As shown in the following table, there are "drug payment stages" for your prescription drug coverage under TRS-Care Medicare Rx. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 *Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because you have no deductible, this payment stage does not apply to you. (Details are in Section 4 of this chapter.)	You begin in this payment stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost for your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $4,430. (Details are in Section 5 of this chapter.)	Due to the additional coverage provided by TRS, you have the same copayment or coinsurance that you had during the Initial Coverage Stage. Therefore, **you may see no change in your copayment and/or coinsurance** until you qualify for catastrophic coverage. You stay in this stage until your year-to-date **"Medicare out-of-pocket costs"** (your payments) reach a total of $7,050. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year (through December 31, 2022). (Details are in Section 7 of this chapter.)

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

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

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

- We keep track of how much you have paid. This is called your "**out-of-pocket**" 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 the plan.

Our plan will prepare a written summary called the *Part D Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the previous month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1, 2022.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost sharing for each prescription claim that may be available.
- **Any additional prescription drug coverage you receive from TRS will show up in a separate table on your *Explanation of Benefits.***

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

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

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

SECTION 4 There is no deductible for TRS-Care Medicare Rx

Section 4.1 You do not pay a deductible for your Part D prescription drugs

You have no deductible for TRS-Care Medicare Rx. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 of this chapter for information about your coverage in the Initial Coverage Stage.

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

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

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

The plan has three Cost Sharing Tiers

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

Cost Sharing Tier 1: Generic

Cost Sharing Tier 2: Preferred Brand

Cost Sharing Tier 3: Non-Preferred Brand

To find out which cost sharing tier your drug is in, look it up in the 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 our plan's network
- The plan's mail-order pharmacy
- A pharmacy that is not in the plan's network

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

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

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

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

As shown in the following table, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug or the copayment amount, *whichever is lower*.

We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy. If you go to an out-of-network pharmacy, you must submit a paper claim form to us.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Network Retail Pharmacy (Up to a 31-day supply)	**Mail-Order Pharmacy** (Up to a 31-day supply)	**Long-Term Care (LTC) Pharmacy** (Up to a 31-day supply)
Tier 1: Generic	$5.00	$15.00	$5.00
Tier 2: Preferred Brand	$25.00	$70.00	$25.00
Tier 3: Non-Preferred Brand	$50.00	$125.00	$50.00

Please note, if you go to an out-of-network pharmacy, and are in one of the limited situations described in Chapter 3, Section 2.5, you will be reimbursed the cost of the drug less your cost share.

Costs shown in the table above reflect the additional coverage that may be provided by TRS. Drugs that are part of your standard Medicare plan, but do not have additional coverage from TRS would be covered under the 2022 Medicare Part D Defined Standard Benefit. Please visit ***https://q1medicare.com/PartD-The-2022-Medicare-Part-D-Outlook.php*** for more information about the 2022 Medicare Part D Defined Standard Benefit drug costs.

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

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

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

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

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

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3, Section 2.4.)

The following table shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Network Retail Pharmacy (Up to a 90-day supply)	**Mail-Order Pharmacy** (Up to a 90-day supply)
Tier 1: Generic	$15.00 (Retail Plus Only)	$15.00
Tier 2: Preferred Brand	$70.00 (Retail Plus Only)	$70.00
Tier 3: Non-Preferred Brand	$125.00 (Retail Plus Only)	$125.00

Please note, if you go to an out-of-network pharmacy, and are in one of the limited situations described in Chapter 3, Section 2.5, you will be reimbursed the cost of the drug less your cost share.

Note: You pay the same share of the cost for your drug filled through the Mail-Order Pharmacy, whether you get a one-month supply or a long-term supply. This means that the copayment or coinsurance listed above is applicable for any order, regardless of the day supply.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,430

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,430 limit for the Initial Coverage Stage**.

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

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
    - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2022, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

TRS provides 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 toward your initial coverage limit or Medicare Part D total out-of-pocket costs. To find out which drugs our plan covers, please call Customer Care.

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year.

Many people do not reach the $4,430 limit in a year. We will let you know if you reach this $4,430 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, the plan provides some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $7,050

Due to the additional coverage provided by TRS, you have the same copayments or coinsurance that you had during the Initial Coverage Stage. Therefore, you may see no change in your copayment and/or coinsurance until you qualify for catastrophic coverage.

Medicare has rules about what counts and what does *not* count as your Medicare Part D out-of-pocket costs. When you reach the Medicare out-of-pocket limit of $7,050, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

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

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

These payments <u>are included</u> in your out-of-pocket costs

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

The amount you pay for drugs when you are in any of the following drug payment stages:

- The Deductible Stage.
- The Initial Coverage Stage.
- The Coverage Gap Stage.

Any payments you made during this plan year under another Medicare prescription drug plan before you joined our plan.

It matters who pays:

If you make these payments **yourself**, they are included in your out-of-pocket costs.

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

Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included, but the amount the plan pays for your drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $7,050 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are <u>not included</u> in your Medicare out-of-pocket costs

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

Drugs you buy outside the United States and its territories.

Drugs that are not covered by our plan.

Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.

Prescription drugs covered by Part A or Part B.

Payments you make toward drugs covered under the additional coverage provided by TRS but not normally covered in a Medicare prescription drug plan.

Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.

Payments made by the plan for your brand or generic drugs while in the coverage gap.

Payments for your drugs that are made by group health plans including employer health plans.

Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.

Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

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

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

We will help you. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your Medicare out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $7,050 in Medicare out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up-to-date.

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

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

You qualify for the Catastrophic Coverage Stage when your Medicare out-of-pocket (also known as TrOOP) costs have reached the $7,050 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year and the plan will pay for most of the cost of your drugs.

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay 5% of the cost for a covered drug but not greater than the cost share amounts listed in the Initial Coverage Stage section above.

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

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

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

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

What do you pay for a Part D vaccination?

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

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

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

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

- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember, you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage of your benefit.

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

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

Our plan will pay the remainder of the costs.

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

When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.

You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking the plan to pay its share of the costs for covered prescription drugs*).

You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

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

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

When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.

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

Section 8.2 You may want to call Customer Care 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 Care whenever you are planning to get a vaccination. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.

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

CHAPTER 5

Asking the plan to pay its share of the costs for covered prescription drugs

Chapter 5. Asking the plan to pay its share of the costs for covered prescription drugs

SECTION 1 Situations in which you should ask the plan to pay its share of the cost of your covered prescription drugs

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

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

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

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

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

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
- If you use an out-of-network pharmacy, we will reimburse you your total cost minus your cost share amount for the drug. You must submit a paper claim in order to be reimbursed.

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

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

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

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

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

- For example, the prescription drug may not be on the plan's *Formulary (List of Covered Drugs)*, 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 prescription drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

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

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

- Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Care are printed on the back cover of this booklet.)
- Ensure you provide this information no later than three (3) years from the date of service. Claims submitted after that date may not be processed.

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

SECTION 2 How to ask us to pay you back

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

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

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

- You don't have to use the form, but it's helpful for our plan to process the information faster.
- Call Customer Care and ask for the form. (Phone numbers are printed on the back cover of this booklet.)

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

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

You must submit your claim to us within three (3) years of the date you received the service, item, or prescription drug.

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

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

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

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

- If we decide that the prescription drug is covered and you followed all the rules for getting the prescription drug, we will pay for our share of the cost. (Chapter 3, Section 2.5 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will mail payment within 30 days after your request was received.
- If we decide that the prescription drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

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

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

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

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

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

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

1. When you buy the prescription drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage or Coverage Gap Stage you can buy your prescription drug **at a network pharmacy** for a price that is lower than our price.

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

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

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

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

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

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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

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

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

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with SilverScript Insurance Company, Grievance Department, P.O. Box 14834, Lexington, KY 40512. Fax 1-724-741-4956. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this *Evidence of Coverage* or you may contact Customer Care for additional information.

Sección 1.1 Debemos proporcionar información de una manera que le sea útil a usted (en otros idiomas además de inglés, en braille, en texto con letras grandes, o en otros formatos alternativos, etc.)

Si desea que le enviemos información de manera que le resulte útil, por favor, llame a Cuidado al Cliente (los números de teléfono están impresos en la parte de atrás de este manual).

Nuestro plan tiene personal y servicio de intérpretes gratis disponibles para responder las preguntas de los miembros discapacitados y que no hablan inglés. También podemos darle información en braille, en letras grandes o en formatos alternos sin costo alguno, si lo necesita. Estamos obligados a darle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una forma que le resulte útil, llame al Cuidado al Cliente (los teléfonos están al dorso de este manual).

Si tiene algún problema en obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja ante SilverScript Insurance Company, Grievance Department, P.O. Box 14834, Lexington, KY 40512. Fax 1-724-741-4956. Usted también puede presentar una queja ante Medicare, llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto está incluida en esta *Evidencia de Cobertura* o puede comunicarse con el Cuidado al Cliente para obtener información adicional.

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

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

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held 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 work with your health care provider to decide whether the changes should be made.

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

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

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

As a member of TRS-Care Medicare Rx, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternative formats.) If you want any of the following kinds of information, please call Customer Care (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star 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 the plan's network, see the *Pharmacy Directory.*
  - For more detailed information about our pharmacies, you can call Customer Care (phone numbers are printed on the back cover of this booklet) or visit our website at info.caremark.com/trscaremedicarerx.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet. These chapters, together with the *Formulary (List of Covered Drugs)*, tell you what prescription drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain prescription drugs.
  - TRS is providing additional coverage, and most prescription drugs will be covered. Please contact Customer Care for more information.
  - If you have questions about the rules or restrictions, please call Customer Care (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a Part D prescription 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 prescription 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 prescription drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask the 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 our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.5 We must support your right to make decisions about your care

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state licensing board. Your State Department of Health may be able to help you find the appropriate agency. Please see the Appendix at the end of this booklet to find the contact information for your State Department of Health.

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

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

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

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Customer Care** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see Chapter 2, Section 3.
- Or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

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

- You can **call Customer Care** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

- ***Get familiar with your covered prescription drugs and the rules you must follow to get these covered prescription 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 prescription drugs.
    - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** Please call Customer Care to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered prescription drugs from our plan. This is called **"coordination of benefits**" because it involves coordinating the prescription drug benefits you get from our plan with any other prescription drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, see Chapter 1, Section 10.)
- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** Show your plan membership card whenever you get your Part D prescription drugs.
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***

  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the prescription drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Pay what you owe.*** As a plan member, you are responsible for these payments:
  - You, or TRS, must pay your plan premiums to continue being a member of our plan.
  - For most of your prescription drugs covered by the plan, you must pay your share of the cost when you get the prescription drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your Part D prescription drugs.
  - If you get any prescription drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a prescription drug, you can make an appeal. Please see Chapter 7 of this booklet for more information about how to make an appeal.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- ***Tell us if you move.*** If you are going to move, it's important to tell us right away. Call Customer Care (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our 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, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - **When moving, you should always contact the benefits administrator for TRS and update your address.**
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- ***Call Customer Care for help if you have questions or concerns.*** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Care are printed on the back cover of this booklet.

- For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

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

SECTION 1 Introduction

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

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

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

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

Which one do you use? The guide in Section 3 of this chapter will help you identify the right process to use.

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in the Appendix 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 (www.medicare.gov).

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is <u>not</u> about benefits or coverage.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

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

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

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

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

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

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

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

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

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

- **This section is about your Part D prescription 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 *Formulary (List of Covered Drugs)*, rules and restrictions on coverage, and cost information, see Chapter 3 (*Using the plan's coverage for your Part D prescription drugs*) and Chapter 4 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

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

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

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *Formulary (List of Covered Drugs)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier, if applicable to your plan
- 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 the plan's *Formulary (List of Covered Drugs)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal. Use the following chart to help you determine which part has information for your situation:

Which of these situations are you in?

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

Section 5.2 What is an exception?

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

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

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

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

   If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost sharing amount that applies to drugs in the highest tier (excluding High Cost Tier, if applicable). You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *Formulary (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:

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

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

3. **Changing coverage of a drug to a lower cost sharing tier,** if applicable to your plan. Every drug on our Drug List is in one of three cost sharing tiers. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.

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

If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost sharing tier than your drug, you can ask us to cover your drug at the cost sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.

- If the drug you're taking is a biological product, you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug, you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

- If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

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

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

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

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, see Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision or making an appeal about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request asking us to pay for our share of the cost of a prescription 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 us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking the plan to pay its share of the costs for covered prescription drugs.* Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 of this chapter for more information about exception requests.
- **We must accept any written request,** including a request submitted on the "CMS Model Coverage Determination Request Form."

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

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.

- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision only if you are asking for a *drug you have not yet received*. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
    - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

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

Deadlines for a "fast" coverage decision

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

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

- 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 Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
    - For details on how to reach us by phone, fax, mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision or making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are asking for a coverage decision or making an appeal about your Part D prescription drugs)*.

- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or making an appeal about your Part D prescription drugs).*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
    - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
    - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

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

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

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

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

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can 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 for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast appeal."
    - 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 talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - 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 you can appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not give you a decision within 14 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 talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

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

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

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

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

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

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

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell 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.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

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

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

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the Independent 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 Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested.**
- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

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

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

SECTION 6 Taking your appeal to Level 3 and beyond

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

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

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

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

Level 3 Appeal	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

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

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

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

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

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

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

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

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

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

Legal Terms

What this section calls a **"complaint"** is also called a **"grievance."**

Another term for **"making a complaint"** is **"filing a grievance."**

Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know. Call 1-866-884-9478, 24 hours a day, 7 days a week. TTY users should call 711.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You may submit a grievance via fax at 1-724-741-4956. Or you may send it to us in writing to:

  SilverScript Insurance Company
  Prescription Drug Plans
  Grievance Department
  P.O. Box 14834
  Lexington, KY 40512

  Upon receipt of your complaint, we will initiate the grievance process.

  - We will respond to you in writing if you ask for a written response or file a written complaint (grievance). Or if your complaint is related to quality of care, we will respond to you in writing.
  - We must notify you of our decision about your complaint (grievance) as quickly as your situation requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Process. You are entitled to a fast review of your complaint in the following situations:
  - We deny your request for a fast review of a request for drug benefits.

- We deny your request for a fast review of an appeal of denied drug benefits.

- You may request an Expedited Grievance by calling Customer Care at the number above. We will contact you within 24 hours by phone to notify you of our response. This will also be followed up by a written response.
- **Whether you call or write, you should contact Customer Care right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

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

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

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

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

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

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

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

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

Section 7.5 You can also tell Medicare about your complaint

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

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

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

Ending your membership in TRS-Care Medicare Rx may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
    - For standard Medicare Part D plans, there are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 of this chapter tells you *when* you can end your membership in the plan. Please note: This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than TRS-Care Medicare Rx, you will lose your medical and prescription drug coverage provided by TRS.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 of this chapter 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 of this chapter tells you about situations when we must end your membership.

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

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year. This is known as a Special Enrollment Period (see Section 2.2 of this chapter for more information on the Special Enrollment Period).

Please note: This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than TRS-Care Medicare Rx, you will lose your medical and prescription drug coverage provided by TRS.

Section 2.1 You can end your membership during the Annual Enrollment Period

For standard Medicare Part D plans, you can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment 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?** From October 15 to December 7, 2021.
- **What type of plan can you switch to during the Annual Enrollment Period?** 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:

- Another Medicare prescription drug plan.
- Original Medicare *without* a separate Medicare prescription drug plan.
  - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a prescription drug plan, unless you have opted out of automatic enrollment.
- – *OR* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
  - If you enroll in most individual Medicare health plans, you will be disenrolled from TRS-Care Medicare Rx when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D prescription drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep TRS-Care Medicare Rx for your prescription drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.
- **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare prescription drug plan later. "Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

Please note: This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than TRS-Care Medicare Rx, you will lose your medical and prescription drug coverage provided by TRS.

- **Please note:** This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than TRS-Care Medicare Rx, you will lose your medical and prescription drug coverage provided by TRS.

- **When will your membership end?** Your membership will end when your new plan's coverage begins.

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

- In certain situations, members of TRS-Care Medicare Rx 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 may be eligible to end your membership during a Special Enrollment Period. These are just examples. For the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - If you have moved out of your plan's service area.

- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Care (phone numbers are printed on the back cover of this booklet).
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - **Another Medicare** prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a prescription drug plan, unless you have opted out of automatic enrollment.
  - – *OR* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most individual Medicare health plans, you will be disenrolled from TRS-Care Medicare Rx when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D prescription drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep TRS-Care Medicare Rx for your prescription drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

- **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare prescription drug plan later. "Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

- **Please note:** This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than TRS-Care Medicare Rx, you will lose your medical and prescription drug coverage provided by TRS.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

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

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

- You can **call Customer Care** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2022*** handbook.
  - Everyone with Medicare receives a copy of the *Medicare & You* handbook each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

Usually, to end your membership in our plan, you simply enroll in another Medicare prescription drug plan during one of the enrollment periods (see Section 2 of this chapter for information about the enrollment periods). However, there may be circumstances in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep TRS-Care Medicare Rx for your prescription drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.

Please note: This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than TRS-Care Medicare Rx, you will lose your medical and prescription drug coverage provided by TRS. If you want to leave our plan, there are two ways you can ask to be disenrolled:

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

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare prescription drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

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

If you would like to switch from our plan to:	This is what you should do:
Another Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from TRS-Care Medicare Rx when your new plan's coverage begins.
A Medicare health plan.	Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from TRS-Care Medicare Rx when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep TRS-Care Medicare Rx for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must contact TRS Health & Insurance Benefits at 1-888-237-6762, Monday - Friday, 7 a.m. - 6 p.m., Central time, or 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.)
Original Medicare *without* a separate Medicare prescription drug plan. **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.	Contact TRS Health & Insurance Benefits at 1-888-237-6762, Monday - Friday, 7 a.m. - 6 p.m., Central time. You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

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

If you leave TRS-Care Medicare Rx, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 of this chapter for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.

If you use an out-of-network pharmacy, we will reimburse you your total cost minus your share of the cost for the prescription drug. You must submit a paper claim in order to be reimbursed. Please see Chapter 3, Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.

SECTION 5 TRS-Care Medicare Rx must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

TRS-Care Medicare Rx must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
    - If you move or take a long trip, you need to call Customer Care to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Care are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount (Part D–Income Related Monthly Adjustment Amount or Part D–IRMAA) because of your income and you do not pay it, Medicare will disenroll you from our plan. If you are disenrolled from the plan, you will lose prescription drug coverage.

Where can you get more information?

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

- You can **call Customer Care** (phone numbers are printed on the back cover of this booklet).

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

TRS-Care Medicare Rx is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

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

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

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Other important legal notices

Prescription drug names listed in this and any other plan documents are the registered and/or unregistered trademarks of third-party pharmaceutical companies unrelated to and unaffiliated with SilverScript Insurance Company or its affiliates. We include these trademarks here for informational purposes only and do not imply or suggest affiliation between the plan sponsor and such third-party pharmaceutical companies.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Annual Enrollment Period – A set time each fall when members can change their health or prescription drug plans or switch to Original Medicare.

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

Brand Name Prescription Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the prescription drug. Brand name prescription 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 prescription drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your prescription drugs after you or other qualified parties on your behalf have spent $7,050 in covered prescription drugs during the covered year.

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

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

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

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

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

Cost Sharing Tier – If applicable for your plan, every prescription drug on the list of covered prescription drugs is in one of three cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the prescription drug.

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

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

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

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

Daily Cost Sharing Rate – A "daily cost sharing rate" may apply when your doctor prescribes less than a full month's supply of certain prescription drugs for you and you are required to pay a copayment. A daily cost sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a prescription drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before a plan begins to pay.

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

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

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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

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

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

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as Part D-IRMAA. Part D-IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible, if applicable to your plan, and before your total prescription drug costs, including amounts you have paid and what our plan has paid on your behalf for the year, have reached $4,430.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

There is an exception: if your birthday falls on the first of any month, your 7-month IEP begins and ends one month sooner. For example, if your birthday is July 1, your 7-month IEP is the same as if you were born in June — beginning in March and ending in September.

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

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In 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 Advantage health plan that is offered in their area.

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

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name prescription drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain prescription drug manufacturers. For this reason, most, but not all, brand name prescription drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B.

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

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

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

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

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

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the 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 our plan to coordinate or provide covered prescription drugs to members of our plan.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost sharing requirement to pay for a portion of prescription drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Medicare True Out-of-Pocket (TrOOP) – The expenses that count toward a person's Medicare prescription drug plan out-of-pocket threshold (for example, $7,050 in 2022). This includes amounts paid by you or qualified payers on your behalf toward the cost of your covered Medicare Part D prescription drugs. Generally, payments by family and friends and charities count toward TrOOP but not payments by other health plans. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin. In other words, TrOOP defines when you exit the coverage gap (sometimes referred to as the "donut hole") and enter the Catastrophic Coverage Stage of your Medicare Part D prescription drug plan.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Care or see the Appendix of this booklet (phone numbers are printed on the back cover of this booklet).

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

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

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

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

Preferred Cost Sharing – Preferred cost sharing means lower costs for certain covered Part D prescription drugs at preferred network pharmacies.

Preferred Network Pharmacy – A network retail pharmacy that accepts the plan's preferred cost sharing.

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

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

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

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

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

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

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

Standard Network Pharmacy – A network retail pharmacy that accepts the plan's standard cost sharing.

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

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

Plan Service Areas			
Region	**States in Service Area**	**Region**	**States in Service Area**
01	Maine and New Hampshire	**18**	Missouri
02	Connecticut, Massachusetts, Rhode Island and Vermont	**19**	Arkansas
03	New York	**20**	Mississippi
04	New Jersey	**21**	Louisiana
05	Delaware, District of Columbia and Maryland	**22**	Texas
06	Pennsylvania and West Virginia	**23**	Oklahoma
07	Virginia	**24**	Kansas
08	North Carolina	**25**	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming
09	South Carolina	**26**	New Mexico
10	Georgia	**27**	Colorado
11	Florida	**28**	Arizona
12	Alabama and Tennessee	**29**	Nevada
13	Michigan	**30**	Oregon and Washington
14	Ohio	**31**	Idaho and Utah
15	Indiana and Kentucky	**32**	California
16	Wisconsin	**33**	Hawaii
17	Illinois	**34**	Alaska

Quality Improvement Organizations (QIO)	
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	**KEPRO,** 5700 Lombardo Center Drive, Suite 100, Seven Hills, OH 44131, Phone: 1-888-319-8452, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: https://www.keproqio.com
Region 2: New Jersey, New York, Puerto Rico, Virgin Islands	**Livanta,** Livanta LLC - BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701, Phone: 1-866-815-5440, TTY: 1-866-868-2289, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.livantaqio.com/en
Region 3: Delaware, Maryland, Pennsylvania, Virginia, Washington, DC, West Virginia	**Livanta,** Livanta LLC - BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701, Phone: 1-888-396-4646, TTY: 1-888-985-2660, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.livantaqio.com/en
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**KEPRO,** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-317-0751, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: https://www.keproqio.com
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	**Livanta,** Livanta LLC - BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701, Phone: 1-888-524-9900, TTY: 1-888-985-8775, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.livantaqio.com/en
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	**KEPRO,** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-315-0636, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: https://www.keproqio.com
Region 7: Iowa, Kansas, Missouri, Nebraska	**Livanta,** Livanta LLC - BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701, Phone: 1-888-755-5580, TTY: 1-888-985-9295, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.livantaqio.com/en
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	**KEPRO,** 5700 Lombardo Center Drive, Suite 100, Seven Hills, OH 44131, Phone: 1-888-317-0891, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: https://www.keproqio.com
Region 9: Arizona, California, Hawaii, Nevada, Pacific Islands	**Livanta,** Livanta LLC - BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701, Phone: 1-877-588-1123, TTY: 1-855-887-6668, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.livantaqio.com/en
Region 10: Alaska, Idaho, Oregon, Washington	**KEPRO,** 5700 Lombardo Center Drive, Suite 100, Seven Hills, OH 44131, Phone: 1-888-305-6759, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: https://www.keproqio.com

State Medicaid Offices	
AK	**Alaska Department of Health and Social Services,** 4501 Business Park Blvd., Building L, Anchorage, AK 99503-7167, Phone: 1-800-780-9972, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://www.dhss.alaska.gov/default.htm?aspxerrorpath=/dpa/Pages/medicaid/default.aspx
AL	**Alabama Medicaid Agency,** Medicaid, P.O. Box 5624, Montgomery, AL 36103, Phone: 1-800-362-1504, 334-242-5000, TTY: 1-800-253-0799, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://medicaid.alabama.gov/
AR	**Arkansas Medicaid,** P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437, Phone: 1-800-482-8988 - Eligibility, 1-800-482-5431 - Other services, TTY: 501-682-8933, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://medicaid.mmis.arkansas.gov/
AZ	**Arizona Health Care Cost Containment System,** 801 E. Jefferson Street, Phoenix, AZ 85034, Phone: 1-800-654-8713, TTY: 1-800-842-6520, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.azahcccs.gov/
CA	**California Department of Health Services Medi-Cal,** P.O. Box 989725, West Sacramento, CA 95798-9725, Phone: 1-800-541-5555, 1-800-300-1506, TTY: 1-888-889-4500, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.dhcs.ca.gov/individuals/Pages/Steps-to-Medi-Cal.aspx
CO	**HealthFirst Colorado,** 1570 Grant Street, Denver, CO 80203-1818, Phone: 1-800-221-3943, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.healthfirstcolorado.com/
CT	**HUSKY, Connecticut's Health Care for Children & Adults,** 55 Farmington Ave., Hartford, CT 06105-3724, Phone: 1-855-626-6632, TTY: 1-800-842-4524, Hours: Monday–Friday 7:30 AM to 4:00 PM, Website: https://portal.ct.gov/HUSKY/Welcome
DC	**The Department of Health Care Finance - DHCF,** 441 4th Street, NW, 900S, Washington, DC 20001, Phone: 202-442-5988, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, Website: https://dhcf.dc.gov/service/medicaid
DE	**Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA),** DHSS Herman Holloway Campus, Lewis Building, 1901 N. DuPont Highway, New Castle, DE 19720, Phone: 1-800-372-2022, 302-255-9500, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dhss.delaware.gov/dhss/dmma/medicaid.html
FL	**Florida Agency for Health Care Administration - Division of Medicaid**, 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308, Phone: 1-850-412-4000, TTY: 1-800-955-8771, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://ahca.myflorida.com/Medicaid/index.shtml
GA	**Georgia Medicaid,** Division of Family and Children Services, Customer Contact Center, P.O. Box 4190, Albany, GA 31706, Phone: 1-877-423-4746, TTY: 1-800-255-0135, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://medicaid.georgia.gov/
HI	**State of Hawaii Department of Human Services Med-QUEST Division,** P.O. Box 3490, Honolulu, HI 96811-3490, Phone: 808-524-3370 - Oahu, 1-800-316-8005 - Neighbor Islands, TTY: 808-692-7182 - Oahu, 1-800-603-1201 - Neighbor Islands, Hours: Monday–Friday 7:30 AM to 4:30 PM, Website: https://medquest.hawaii.gov/
IA	**IA Health Link,** P.O. Box 36510, Des Moines, IA 50315, Phone: 1-800-338-8366, 515-256-4606, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dhs.iowa.gov/iahealthlink

State Medicaid Offices	
ID	**Idaho Department of Health and Welfare,** P.O. Box 83720, Boise, ID 83720-0036, Phone: 1-877-456-1233, TTY: 1-888-791-3004, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://healthandwelfare.idaho.gov/services-programs/medicaid-health
IL	**Illinois Department of Healthcare and Family Services,** Central Scan Unit (CSU), P.O. Box 19138, Springfield, IL 62763, Phone: 1-800-843-6154, TTY: 1-866-324-5553, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.illinois.gov/hfs/Pages/default.aspx
IN	**Indiana Medicaid,** 402 W. Washington Street, Room W392, P.O. Box 7083, Indianapolis, IN 46204, Phone: 1-800-403-0864, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.in.gov/medicaid/
KS	**KanCare Medicaid for Kansas,** P.O. Box 3599, Topeka, KS 66601, Phone: 1-800-792-4884, TTY: 1-800-792-4992, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.kancare.ks.gov/
KY	**Kentucky Cabinet for Health and Family Services, Department for Medicaid Services,** 275 E. Main Street, Frankfort, KY 40621, Phone: 1-800-635-2570, 1-855-306-8959, 502-564-3852, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://chfs.ky.gov/agencies/dms/Pages/default.aspx
LA	**Louisiana Department of Health,** P.O. Box 629, Baton Rouge, LA 70821-0629, Phone: 1-888-342-6207, TTY: 1-800-220-5404, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://ldh.la.gov/index.cfm/subhome/1/n/10
MA	**MassHealth,** 100 Hancock Street, 6th Floor, Quincy, MA 02171, Phone: 1-800-841-2900, TTY: 1-800-497-4648, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.mass.gov/orgs/masshealth
MD	**Maryland Medicaid,** Herbert R. O'Conor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, Phone: 1-877-463-3464, 1-855-642-8572, TTY: 1-855-642-8573, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://mmcp.health.maryland.gov/Pages/home.aspx
ME	**Office of MaineCare Services,** Office for Family Independence, 114 Corn Shop Lane, Farmington, ME 04938, Phone: 1-855-797-4357, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.maine.gov/dhhs/ofi/programs-services/health-care-assistance
MI	**Michigan Medicaid Program,** Capital View Building, 333 S. Grand Ave., P.O. Box 30195, Lansing, Michigan 48909, Phone: 1-800-642-3195, 855-276-4627, TTY: 1-866-501-5656, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446---,00.html
MN	**Minnesota Department of Human Services, Medical Assistance (MA),** P.O. Box 64993, St. Paul, MN 55164-0993, Phone: 1-800-657-3739, 651-431-2670, TTY: 1-800-627-3529, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
MO	**MO HealthNet,** 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-3425, Phone: 1-800-392-2161, TTY: 1-800-735-2466, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://mydss.mo.gov/healthcare
MS	**Mississippi Division of Medicaid,** MS Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201, Phone: 1-800-421-2408, 601-659-6050, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://medicaid.ms.gov/

State Medicaid Offices	
MT	**Montana Medicaid and HMK Plus,** 111 North Sanders Street, Helena, MT 59601-4520, P.O. Box 4210, Helena, MT 59604-4210, Phone: 1-800-362-8312, 1-888-706-1535, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
NC	**NC Medicaid - Division of Health Benefits,** 2501 Mail Service Center, Raleigh, NC 27699-2501, Phone: 1-888-245-0179, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://medicaid.ncdhhs.gov/
ND	**North Dakota Department of Human Services - Medical Services Division,** 600 E. Boulevard Ave., Dept 325, Bismarck, ND 58505-0250, Phone: 1-800-755-2604, 701-328-7068, TTY: 1-800-366-6888, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
NE	**Nebraska Department of Health and Human Services System,** 301 Centennial Mall South, Lincoln, NE 68508, Phone: 1-855-632-7633, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dhhs.ne.gov/Pages/General-Medicaid-Information.aspx
NH	**New Hampshire Department of Health and Human Services,** Office of Medicaid Business & Policy, NH Department of Health & Human Services, 129 Pleasant Street, Concord, NH 03301, Phone: 1-800-852-3345, x4344, 603-271-4344, TTY: 1-800-735-2964, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.dhhs.nh.gov/ombp/medicaid/
NJ	**State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services,** 222 South Warren Street, P.O. Box 700, Trenton, NJ 08625-0700, Phone: 1-800-356-1561, 1-800-701-0710, TTY: 1-800-701-0720, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/
NM	**Centennial Care,** NM Human Services Department, P.O. Box 2348, Santa Fe, NM 87504, Phone: 1-800-283-4465, TTY: 1-855-227-5485, Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: https://www.hsd.state.nm.us/lookingforassistance/centennial-care-overview/
NV	**Nevada Department of Health and Human Services,** Division of Welfare and Supportive Services, P.O. Box 30042, Reno, NV 89520-3042, Phone: 1-877-638-3472, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dwss.nv.gov/
NY	**New York State Department of Health Office of Medicaid Management,** New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, Phone: 1-800-541-2831, 518-486-9057, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.health.ny.gov/health_care/medicaid/
OH	**Ohio Department of Medicaid,** 50 W. Town Street, Suite 400, Columbus, OH 43215, Phone: 1-800-324-8680, TTY: 711, Hours: Monday–Saturday 9:00 AM to 5:00 PM, Website: https://www.medicaid.ohio.gov/
OK	**SoonerCare,** 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, Phone: 1-800-987-7767, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://oklahoma.gov/ohca.html
OR	**Oregon Health Plan,** 500 Summer Street NE, E-20, Salem, OR 97301-1063, Phone: 1-800-273-0557, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.oregon.gov/oha/hsd/ohp/Pages/index.aspx

State Medicaid Offices	
PA	**Pennsylvania Department of Human Services,** 625 Forster Street, Harrisburg, PA 17120, Phone: 1-800-692-7462, TTY: 1-800-451-5896, 711, Hours: Monday–Thursday 8:00 AM to 5:00 PM and Friday 8:30 AM to 5:00 PM, Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
RI	**Rhode Island Department of Human Services,** P.O. Box 8709, Cranston, RI 02920-8787, Phone: 1-855-697-4347, TTY: 711, Hours: Monday–Friday 8:30 AM to 3:00 PM, Website: http://dhs.ri.gov/applynow/
SC	**South Carolina Healthy Connections Medicaid,** SCDHHS, P.O. Box 100101, Columbia, SC 29202, Phone: 1-888-549-0820, TTY: 1-888-842-3620, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: https://www.scdhhs.gov/
SD	**Department of Social Services of South Dakota,** 700 Governors Drive, Pierre, SD 57501, Phone: 1-800-597-1603, 1-800-305-3064, 605-773-3165, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dss.sd.gov/medicaid/
TN	**Division of TennCare,** 310 Great Circle Road, Nashville, TN 37243, Phone: 1-855-259-0701 - Applications, 1-800-342-3145 - General, TTY: 1-877-779-3103, Hours: Monday–Friday 7:00 AM to 7:00 PM, Website: https://www.tn.gov/tenncare
TX	**Texas Health and Human Services Commission,** 4900 N. Lamar Boulevard, Austin, TX 78751-2316, Phone: 1-800-252-8263, TTY: 1-800-735-2989, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://hhs.texas.gov/services/health/medicaid-chip
UT	**Utah Department of Health Medicaid,** P.O. Box 143106, Salt Lake City, UT 84114-3106, Phone: 1-800-662-9651, TTY: 711, Hours: Monday, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM and Thursday 11:00 AM to 5:00 PM, Website: https://medicaid.utah.gov/
VA	**Virginia Medicaid,** 600 E. Broad Street, Suite 1300, Richmond, VA 23219, Phone: 1-855-242-8282, TTY: 1-888-221-1590, Hours: Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, Website: https://www.dmas.virginia.gov/
VT	**State of Vermont Green Mountain Care,** Green Mountain Care, Health Access Member Services, Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250- 8427, 1-855-899-9600, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.greenmountaincare.org/mabd
WA	**Washington Apple Health,** Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501, Phone: 1-800-562-3022, TTY: 711, Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage
WI	**Wisconsin Department of Health Services,** Division of Medicaid Services, P.O. Box 309, Madison, WI 53707-0309, Phone: 1-800-362-3002, 608-266-1865, TTY: 1-800-947-3529, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.dhs.wisconsin.gov/medicaid/index.htm
WV	**West Virginia Department of Health & Human Resources, Bureau for Medical Services,** One Davis Square, Suite 100 East, Charleston, WV 25301, Phone: 1-877-716-1212, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://dhhr.wv.gov/Pages/default.aspx
WY	**Wyoming Department of Health, Healthcare Financing Division,** Customer Service Center, 3001 E. Pershing Blvd., Suite 125, Cheyenne, WY 82001, Phone: 1-855-294-2127, 301-777-7531, TTY: 1-855-329-5204, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://health.wyo.gov/

State Health Insurance Assistance Program (SHIP)	
AK	**Alaska State Health Insurance Assistance Programs,** 550 W. 7th Ave., Suite 1230, Anchorage, AK 99501, Phone: 1-800-478-6065, 907-269-3680, TTY: 1-800-770-8973, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://dhss.alaska.gov/default.htm?aspxerrorpath=/dsds/Pages/medicare/ship.aspx
AL	**Alabama State Health Insurance Assistance Program,** RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, Phone: 1-800-243-5463, 1-877-425-2243, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://alabamaageline.gov/ship/
AR	**Senior Health Insurance Information Program (SHIIP) of Arkansas,** 1 Commerce Way, Little Rock, AR 72202, Phone: 1-800-224-6330, TTY: 501-683-4468, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://insurance.arkansas.gov/pages/consumer-services/senior-health/
AZ	**Arizona State Health Insurance Assistance Program,** 1789 W. Jefferson Street, Mail Drop 6288, Phoenix, AZ 85007, Phone: 1-800-432-4040, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://des.az.gov/services/older-adults/medicare-assistance
CA	**California Health Insurance Counseling and Advocacy Program (HICAP),** 1300 National Drive, Suite 200, Sacramento, CA 95834-1992, Phone: 1-800-434-0222, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/
CO	**Colorado Senior Health Insurance Assistance Program (SHIP),** 1560 Broadway, Suite 850, Denver, CO 80202, Phone: 1-888-696-7213, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare
CT	**CHOICES,** 55 Farmington Ave., 12th Floor, Hartford, CT 06105, Phone: 1-800-994-9422, TTY: 1-860-247-0775, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns
DC	**DC State Health Insurance Assistance Program (SHIP),** 500 K Street NE, Washington, DC 20002, Phone: 202-724-5626, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://dacl.dc.gov/
DE	**Delaware Medicare Assistance Bureau (DMAB),** 1351 W. North Street, Suite 101, Dover, DE 19904, Phone: 1-800-336-9500, 302-604-7364, TTY: 711, Hours: Monday–Friday 8:30 AM to 3:30 PM, Website: https://insurance.delaware.gov/divisions/dmab/
FL	**Serving Health Insurance Needs of Elders (SHINE),** 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, Phone: 1-800-963-5337, TTY: 1-800-955-8770, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.floridashine.org/
GA	**GeorgiaCares,** 2 Peachtree Street NW, 33rd Floor, Atlanta, Georgia, 30303, Phone: 1-866-552-4464 Option 4, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://mygeorgiacares.org/
HI	**Hawaii SHIP,** Executive Office on Aging, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, Phone: 808-586-7299 - Oahu, 1-888-875-9229 - Neighbor Islands, TTY: 1-866-810-4379, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: https://hawaiiship.org/
IA	**Iowa Senior Health Insurance Information Program (SHIIP),** 1963 Bell Ave., Suite 100, Des Moines, IA 50315, Phone: 1-800-351-4664, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://shiip.iowa.gov/

State Health Insurance Assistance Program (SHIP)	
ID	**Idaho Senior Health Insurance Benefits Advisors (SHIBA),** 700 W. State Street, 3rd Floor, P.O. Box 83720, Boise, ID 83720-0043, Phone: 1-800-247-4422, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: https://doi.idaho.gov/SHIBA/
IL	**Senior Health Insurance Program (SHIP),** One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, Phone: 1-800-252-8966, TTY: 1-888-206-1327, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://www2.illinois.gov/aging/ship/Pages/default.aspx
IN	**Indiana State Health Insurance Assistance Program,** 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 1-800-452-4800, TTY: 1-866-846-0139, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.in.gov/ship/index.htm
KS	**Senior Health Insurance Counseling for Kansas (SHICK),** New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, Phone: 1-800-860-5260, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick
KY	**Kentucky State Health Insurance Assistance Program,** 275 E. Main Street, Suite 3E-E, Frankfort, KY 40621, Phone: 1-877-293-7447, Option 2, 502-564-6930, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://chfs.ky.gov/agencies/dail/Pages/ship.aspx
LA	**Louisiana Senior Health Insurance Information Program,** 1702 N. Third Street, P.O. Box 94214, Baton Rouge, LA 70802, Phone: 1-800-259-5300, Option 2, 225-342-5900, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: http://www.ldi.la.gov/consumers/senior-health-shiip
MA	**SHINE (Serving the Health Insurance Needs of Everyone),** 1 Ashburton Place, 5th Floor, Boston, MA 02108, Phone: 1-800-243-4636, TTY: 1-800-439-0183, 1-877-752-2388 (Voice), 1-800-439-2370, 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.mass.gov/health-insurance-counseling
MD	**Maryland State Health Insurance Assistance Program,** 301 West Preston Street, Suite 1007, Baltimore, MD 21201, Phone: 1-800-243-3425, 410-767-1100, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://aging.maryland.gov/Pages/state-health-insurance-program.aspx
ME	**Maine State Health Insurance Assistance Program,** 109 Capitol Street, 11 State House Station, Augusta, ME 04333, Phone: 1-877-353-3771, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
MI	**Michigan Medicare/Medicaid Assistance Program (MMAP),** 6105 W. St. Joseph, Suite 204, Lansing, MI 48917, Phone: 1-800-803-7174, TTY: 711, Hours: Monday–Friday 8:00 AM to 7:00 PM, Website: https://mmapinc.org/
MN	**Minnesota State Health Insurance Assistance,** 540 Cedar Street, St. Paul, MN 55164, Phone: 1-800-333-2433, TTY: 1-800-627-3529, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://mn.gov/senior-linkage-line/
MO	**CLAIM,** 1105 Lakeview Ave., Columbia, MO 65201, Phone: 1-800-390-3330, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: https://www.missouriclaim.org/
MS	**Mississippi State Health Insurance Assistance Program,** 200 South Lamar St., Jackson, MS 39201, Phone: 1-800-948-3090, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

State Health Insurance Assistance Program (SHIP)	
MT	**Montana State Health Insurance Assistance Program (SHIP),** P.O. Box 4210, Helena, MT 59604, Phone: 1-800-551-3191, TTY: 1-800-833-8503, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dphhs.mt.gov/SLTC/aging/SHIP.aspx
NC	**Seniors' Health Insurance Information Program (SHIIP),** Albemarle Building, 325 N. Salisbury Street, Raleigh, NC 27603, Phone: 1-855-408-1212, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
ND	**State Health Insurance Counseling Program (SHIC),** 600 E. Boulevard Ave., Bismarck, ND 58505-0320, Phone: 1-888-575-6611, TTY: 1-800-366-6888, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.insurance.nd.gov/shic-medicare
NE	**Nebraska SHIP,** 1033 O Street, Suite 307 (Golds Building), Lincoln, NE 68508, Phone: 1-800-234-7119, 402-271-2841, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://doi.nebraska.gov/consumer/senior-health
NH	**New Hampshire State Health Insurance Assistance Program (SHIP),** 129 Pleasant Street, Concord, NH 03301, Phone: 1-866-634-9412, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.servicelink.nh.gov/medicare/index.htm
NJ	**New Jersey State Health Insurance Assistance Program,** Division of Aging Services, P.O. Box 715, Trenton NJ 08625-0715, Phone: 1-800-792-8820, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://www.state.nj.us/humanservices/doas/services/ship/index.html
NM	**New Mexico State Health Insurance Assistance Program (SHIP),** 2550 Cerrillos Road, Santa Fe, NM 87505, Phone: 1-800-432-2080, 505-476-4846, TTY: 505-476-4937, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: http://www.nmaging.state.nm.us/adrc.aspx
NV	**Nevada State Health Insurance Assistance Program (SHIP),** 3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102, Phone: 1-800-307-4444, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
NY	**Health Insurance Information, Counseling and Assistance (HIICAP),** 2 Empire State Plaza, 5th Floor, Albany, NY 12223, Phone: 1-800-701-0501, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://aging.ny.gov/health-insurance-information-counseling-and-assistance
OH	**Ohio Senior Health Insurance Information Program (OSHIIP),** 50 W. Town Street, Third Floor, Suite 300, Columbus, OH 43215, Phone: 1-800-686-1578, 614-644-2658, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://insurance.ohio.gov/wps/portal/gov/odi/consumers
OK	**Oklahoma Senior Health Insurance Counseling Program (SHIP),** 400 NE 50th Street, Oklahoma City, OK 73105, Phone: 1-800-522-0071, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/
OR	**Oregon Senior Health Insurance Benefits Assistance (SHIBA),** 350 Winter Street NE, Salem, OR 97309-0405, Phone: 1-800-722-4134, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://healthcare.oregon.gov/shiba/pages/index.aspx

State Health Insurance Assistance Program (SHIP)	
PA	**Pennsylvania Medicare Education and Decision Insight,** 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, Phone: 1-800-783-7067, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx
RI	**Senior Health Insurance Program (SHIP),** 25 Howard Ave., Building 57, Cranston, RI 02920, Phone: 1-888-884-8721, TTY: 401-462-0740, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://oha.ri.gov/what-we-do/access/health-insurance-coaching/medicare-counseling
SC	**State Health Insurance Assistance Program (SHIP),** 1301 Gervais Street, Suite 350, Columbia, SC 29201, Phone: 1-800-868-9095, TTY: 1-888-842-3620, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://www.getcaresc.com/guide/insurance-counseling-medicaremedicaid
SD	**Senior Health Information and Insurance Education (SHIINE),** 700 Governors Drive, Pierre, SD 57501, Phone: 1-800-536-8197 Eastern SD, 1-877-331-4834 Central SD, 1-877-286-9072 Western SD, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://shiine.net/
TN	**Tennessee SHIP (State Health Insurance Assistance Program),** 1104 England Drive, Cookeville, TN 38501, Phone: 1-877-801-0044, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://tnmedicarehelp.com/
TX	**Texas Health Information Counseling and Advocacy Program,** 4900 N. Lamar Blvd., Austin, TX 78751-2316, Phone: 1-800-252-9240, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://hhs.texas.gov/services/health/medicare
UT	**Utah Senior Health Insurance Information Program,** 195 N. 1950 W., Salt Lake City, UT 84116, Phone: 1-800-541-7735, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://daas.utah.gov/seniors/
VA	**Virginia Insurance Counseling and Assistance Program (VICAP),** 1610 Forest Avenue, Suite 100, Henrico, VA 23229, Phone: 1-800-552-3402, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.vda.virginia.gov/vicap.htm
VT	**Vermont State Health Insurance Assistance Program (SHIP),** P.O. Box 321, Jericho, Vermont 05465, Phone: 1-800-642-5119, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://vermont4a.org/medicare-information
WA	**Washington Statewide Health Insurance Benefits Advisors (SHIBA),** Office of the Insurance Commissioner, P.O. Box 40255, Olympia, WA 98504-0255, Phone: 1-800-562-6900, TTY: 360-586-0241, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba
WI	**Wisconsin State Health Insurance Assistance Program (SHIP),** 1 W. Wilson Street, Madison, WI 53703, Phone: 1-800-242-1060, TTY: 1-800-947-3529, 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
WV	**WV SHIP,** Town Center Mall, 1900 Kanawha Blvd., East, Charleston, WV 25305, Phone: 1-877-987-3646, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://www.wvship.org/
WY	**Wyoming State Health Insurance Information Program (WSHIIP),** 106 W. Adams Ave., Riverton, WY 82501, Phone: 1-800-856-4398, TTY: 711, Hours: Monday–Friday 7:00 AM to 4:00 PM, Website: http://www.wyomingseniors.com/

State Department of Health	
AK	**Alaska Department of Health and Social Services,** 3601 C Street, Suite 902, Anchorage, AK 99503, Phone: 1-800-478-2221, 907-269-7800, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://dhss.alaska.gov/
AL	**Alabama Department of Public Health,** The RSA Tower, 201 Monroe Street, Montgomery, AL 36104, Phone: 1-800-252-1818, 334-206-5300, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.alabamapublichealth.gov/index.html
AR	**Arkansas Department of Health,** 4815 W. Markham Street, Little Rock, AR 72205-3867, Phone: 1-800-462-0599, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://healthy.arkansas.gov/
AZ	**Arizona Department of Health Services,** 150 North 18th Avenue, Phoenix, Arizona 85007, Phone: 602-542-1025, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://azdhs.gov/
CA	**California Department of Health Care Services,** P.O. Box 997413, MS 0000, Sacramento, CA 95899-7413, Phone: 1-800-541-5555, 916-636-1980, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.dhcs.ca.gov/
CO	**Colorado Department of Public Health and Environment,** 4300 Cherry Creek Drive South, Denver, CO 80246, Phone: 1-800-886-7689, 303-692-2000, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://cdphe.colorado.gov/
CT	**Connecticut State Department of Public Health,** 410 Capitol Ave., Hartford, CT 06134, Phone: 860-509-8000, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://portal.ct.gov/dph
DC	**DC Health,** 899 North Capitol Street NE, Washington, DC 20002, Phone: 202-442-5955, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, Website: https://dchealth.dc.gov/
DE	**Delaware Health and Social Services,** 1901 N. DuPont Highway, Lewis Building, New Castle, DE 19720, Phone: 302-255-9675, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://dhss.delaware.gov/dhss/
FL	**Florida Health,** 4052 Bald Cypress Way, Tallahassee, FL 32399, Phone: 850-245-4444, 850-245-4210, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://www.floridahealth.gov/
GA	**Georgia Department of Community Health,** 2 Peachtree Street NW, Atlanta, GA 30303, Phone: 404-656-4507, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dch.georgia.gov/
HI	**Hawaii State Department of Health,** 1250 Punchbowl Street, Honolulu, HI 96813, Phone: 808-586-4400, TTY: 711, Hours: Monday–Friday 7:45 AM to 2:30 PM, Website: https://health.hawaii.gov/
IA	**Iowa Department of Public Health,** Lucas State Office Building, 321 E. 12th Street, Des Moines, IA 50319-0075, Phone: 1-866-227-9878, 515-281-7689, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://idph.iowa.gov/
ID	**Idaho Department of Health and Welfare,** PO Box 83720, Boise, ID 83720-0036, Phone: 1-800-926-2588, 208-334-5500, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://healthandwelfare.idaho.gov/
IL	**Illinois Department of Public Health,** 525-535 West Jefferson Street, Springfield, IL 62671, Phone: 217-782-4977, TTY: 1-800-547-0466, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dph.illinois.gov/

State Department of Health	
IN	**Indiana Department of Health,** 2 North Meridian Street, Indianapolis, IN 46204, Phone: 1-800-382-9480, 317-233-1325, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, Website: https://www.in.gov/isdh/
KS	**Kansas Department of Health and Environment,** 1000 SW Jackson Street, Suite 540, Topeka, KS 66612-0461, Phone: 785-296-1500, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.kdheks.gov/health/
KY	**Kentucky Cabinet for Health and Family Services,** 275 E. Main Street, Frankfort, KY 40621, Phone: 1-800-372-2973, 502-564-5497, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://chfs.ky.gov/Pages/index.aspx
LA	**Louisiana Department of Health,** 628 N. 4th Street, Baton Rouge, LA 70802, Phone: 225-342-9500, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://ldh.la.gov/
MA	**Massachusetts Department of Public Health,** 250 Washington Street, Boston, MA 02108, Phone: 617-624-6000, TTY: 617-624-6001, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.mass.gov/orgs/department-of-public-health
MD	**Maryland Department of Health,** 201 W. Preston Street, Baltimore, MD 21201-2399, Phone: 1-877-463-3464, 410-767-6500, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://health.maryland.gov/pages/home.aspx
ME	**Maine Department of Health and Human Services,** 109 Capitol Street, 11 State House Station, Augusta, ME 04333, Phone: 207-287-3707, TTY: 711, Hours: Monday–Friday 8:00 AM to 7:00 PM, Website: https://www.maine.gov/dhhs/
MI	**Michigan Department of Health & Human Services,** 333 S. Grand Ave., PO Box 30195, Lansing, MI 48909, Phone: 517-241-3740, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.michigan.gov/mdhhs
MN	**Minnesota Department of Health,** PO Box 64975, St. Paul, MN 55164-0975, Phone: 1-888-345-0823, 651-201-5000, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.health.state.mn.us/
MO	**Missouri Department of Health & Senior Services,** 912 Wildwood, PO Box 570, Jefferson City, MO 65102, Phone: 573-751-6400, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://health.mo.gov/
MS	**Mississippi State Department of Health,** 570 East Woodrow Wilson Drive, Jackson, MS 39216, Phone: 1-866-458-4948, 601-576-7400, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://msdh.ms.gov/
MT	**Montana Department of Public Health & Human Services,** 11 N Sanders Street, Helena, MT 59601, Phone: 1-800-362-8312, TTY: 1-800-833-8503, 406-444-1335, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dphhs.mt.gov/
NC	**North Carolina Department of Health and Human Services,** 2001 Mail Service Center, Raleigh, NC 27699-2000, Phone: 1-800-662-7030, 919-855-4800, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://www.ncdhhs.gov/
ND	**North Dakota Department of Health,** 600 E Boulevard Avenue, Bismarck, ND 58505-0200, Phone: 701-328-2372, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.health.nd.gov/

State Department of Health	
NE	**Nebraska Department of Health and Human Services,** 301 Centennial Mall South, Lincoln, NE 68509, Phone: 402-471-3121, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dhhs.ne.gov/Pages/default.aspx
NH	**New Hampshire Department of Health and Human Services,** 129 Pleasant Street, Concord, NH 03301-3852, Phone: 1-844-275- 3447, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: https://www.dhhs.nh.gov/
NJ	**State of New Jersey Department of Health,** PO Box 360, Trenton, NJ 08625-0360, Phone: 609-292-7838, 609-292-7839, TTY: 1-877-294-4356, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://nj.gov/health/
NM	**New Mexico Department of Health,** Harold Runnels Building, 1190 S. St. Francis Drive, Santa Fe, NM 87505, Phone: 505-827-2613, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.nmhealth.org/
NV	**Nevada Department of Health and Human Services (DHHS),** 4126 Technology Way, Suite 100, Carson City, NV 89706, Phone: 775-684-4000, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dhhs.nv.gov/
NY	**New York State Department of Health,** Corning Tower, Empire State Plaza, Albany, NY 12237, Phone: 1-866-881-2809, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://health.ny.gov
OH	**Ohio Department of Health,** Columbus Offices (Main), 246 N. High Street, Columbus, OH 43215, 35 Chestnut St, Columbus, OH 43215, Phone: 614-466-3543, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://odh.ohio.gov/wps/portal/gov/odh/home
OK	**Oklahoma State Department of Health,** 123 Robert S Kerr Avenue, Suite 1702, Oklahoma City, OK 73102-6406, Phone: 1-800-522-0203, 405-426-8000, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://oklahoma.gov/health.html
OR	**Oregon Health Authority Public Health Division,** 500 Summer Street NE, E-20, Salem, OR 97301-1097, Phone: 1-800-422-6012, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.oregon.gov/OHA/PH/Pages/index.aspx
PA	**Pennsylvania Department of Health,** 625 Forster Street, Harrisburg, PA 17120, Phone: 877-724-3258, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.health.pa.gov/Pages/default.aspx
RI	**Rhode Island Department of Health,** 3 Capitol Hill, Providence, RI 02908, Phone: 401-222-5960, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://health.ri.gov/
SC	**South Carolina Department of Health and Environmental Control (DHEC),** DHEC Constituent Services, 2600 Bull Street, Columbia, SC 29201, Phone: 803-898-3432, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://scdhec.gov/
SD	**South Dakota Department of Health,** 600 E Capitol Avenue, Pierre, SD 57501-2536, Phone: Toll-Free: 1-800-738-2301, 605-773-3361, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://doh.sd.gov/
TN	**Tennessee Department of Health,** 710 James Robertson Parkway, Nashville, TN 37243, Phone: 615-741-3111, TTY: 1-800-848-0298, 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.tn.gov/health

State Department of Health	
TX	**Texas Department of State Health Services,** 1100 W 49th Street, Austin, TX 78756-3199, Phone: 1-888-963-7111, 512-776-7111, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dshs.state.tx.us/Mobile/Mobile.aspx
UT	**Utah Department of Health,** Cannon Health Building, 288 N 1460 W, Salt Lake City, UT 84116, Phone: 1-888-222-2542, 801-538-6003, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://health.utah.gov/
VA	**Virginia Department of Health,** 109 Governor Street, Richmond, VA 23219, Phone: 804-864-7001, TTY: 711, Hours: Monday–Friday 8:15 AM to 5:00 PM, Website: https://www.vdh.virginia.gov/
VT	**Vermont Department of Health,** 108 Cherry Street, Burlington, VT 05402, Phone: 1-800-464-4343, TTY: 711, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: https://www.healthvermont.gov/
WA	**Washington State Department of Health,** 101 Israel Road SE, Tumwater, WA 98501, Phone: Toll-Free: 1-800-525-0127, 360-236-4501, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.doh.wa.gov/
WI	**Wisconsin Department of Health Services,** 1 West Wilson Street, Madison, WI 53703, Phone: 608-266-1865, TTY: 1-800-947-3529, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.dhs.wisconsin.gov/
WV	**West Virginia Department of Health & Human Resources,** One Davis Square, Suite 100 East, Charleston, WV 25301, Phone: 304-558-0684, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://dhhr.wv.gov/Pages/default.aspx
WY	**Wyoming Department of Health,** 401 Hathaway Building, Cheyenne, WY 82002, Phone: 1-866-571-0944, 307-777-7656, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://health.wyo.gov/

State Pharmaceutical Assistance Program (SPAP)	
AL	**Alabama SenioRx Prescription Assistance Program,** RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, Phone: 1-877-425-2243, 334-242-5743, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://alabamaageline.gov/seniorx/
DE	**Delaware Prescription Assistance Program,** DXC DPAP, P.O. Box 950, New Castle, DE 19720-0950, Phone: 1-844-245-9580, TTY: 711, Hours: Monday–Friday 8 :00 AM to 4:30 PM, Website: https://dhss.delaware.gov/dhss/dmma/dpap.html
IN	**HoosierRx,** P.O. Box 6224, Indianapolis, IN 46206, Phone: 1-866-267-4679, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.in.gov/medicaid/members/194.htm
MA	**Massachusetts Prescription Advantage,** P.O. Box 15153, Worcester, MA 01615-0153, Phone: 1-800-243-4636, Option 3, TTY: 1-877-610-0241, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.mass.gov/prescription-drug-assistance
MD	**Maryland Senior Prescription Drug Assistance Program (SPDAP),** Maryland – SPDAP c/o International Software Systems Inc., P.O. Box 749, Greenbelt, Maryland 20768-0749, Phone: 1-800-551-5995, TTY: 1-800-877-5156, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://marylandspdap.com/
ME	**Maine Rx Plus,** Department of Human Services, 242 State Street, Augusta, ME 04333, Phone: 1-866-796-2463, TTY: 1-800-423-4331, 207-287-1828, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://q1medicare.com/PartD-SPAPMaineLowCstRxElderlyDisabled.php
MO	**Missouri Rx Plan (MORx),** P. O. Box 6500, Jefferson City, MO 65102, Phone: 1-800-375-1406, TTY: 1-800-735-2966, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.payingforseniorcare.com/missouri/missouri-rx-plan
MT	**Montana Big Sky Rx Program,** P.O. Box 202915, Helena, MT 59620-2915, Phone: 1-866-369-1233, 406-444-1233, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
NJ	**New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD),** PAAD-HAAAD, Department of Human Services, P.O. Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-9745, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.state.nj.us/humanservices/doas/services/paad/
NJ	**New Jersey Senior Gold Prescription Discount Program,** Division of Aging Services, P.O. Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-9745, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.state.nj.us/humanservices/doas/services/seniorgold/
NV	**Nevada Disability Rx Program,** ADSD, Attn: SRx/DRx, 3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102, Phone: 1-866-303-6323, Option 2, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://adsd.nv.gov/Programs/Physical/DisabilityRx/DisabilityRx/
NV	**Nevada Senior Rx Program,** Department of Health and Human Services, 3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102, Phone: 1-866-303-6323, Option 2, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: https://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

State Pharmaceutical Assistance Program (SPAP)	
NY	**New York State Elderly Pharmaceutical Insurance Coverage,** EPIC, P.O. Box 15018, Albany, NY 12212-5108, Phone: 1-800-332-3742, TTY: 1-800-290-9138, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.health.ny.gov/health_care/epic/
PA	**Pharmaceutical Assistance Contract for the Elderly (PACE/PACENET),** Pennsylvania Department of Aging, P.O. Box 8806, Harrisburg, PA 17105-8806, Phone: 1-800-225-7223, TTY: 1-800-222-9004, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
PA	**Special Pharmaceutical Benefits Program - Mental Health,** Department of Human Services - OMHSAS, Business Partner Support Unit - SPBP-MH Program, Commonwealth Tower, 12th Floor, P.O. Box 2675, Harrisburg, PA 17105-2675, Phone: 1-800-433-4459, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Special-Pharm-Benefits-Program.aspx
PA	**Chronic Renal Disease Program (CRDP),** Pennsylvania Department of Health, Eligibility Unit, P.O. Box 8811, Harrisburg, PA 17105-8811, Phone: 1-800-225-7223, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://www.health.pa.gov/topics/programs/Chronic-Renal-Disease/Pages/Chronic%20Renal%20Disease.aspx
RI	**RI Pharmaceutical Assistance to the Elderly (RIPAE),** 74 West Road, Hazard Building, 2nd Floor, Cranston, RI 02920, Phone: 401-462-3000, TTY: 401-462-0740, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://www.reformwatch.com/development/DEA2/programs/prescription_assist.php
TX	**Kidney Health Care Program (KHC),** Kidney Health Care, MC 1938, P.O. Box 149347, Austin, TX 78714-9347, Phone: 1-800-222-3986, Option 2, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://hhs.texas.gov/services/health/kidney-health-care
VT	**Green Mountain Care,** Green Mountain Care Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250-8427, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:00 PM, Website: https://www.greenmountaincare.org/prescription
WI	**SeniorCare,** P.O. Box 6710, Madison, WI 53716-0710, Phone: 1-800-657-2038, TTY: 711, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: https://www.dhs.wisconsin.gov/seniorcare/index.htm

State AIDS Drug Assistance Programs (ADAP)	
AK	**Alaska AIDS Drug Assistance Program (ADAP),** Anchorage: 1057 W. Fireweed Lane, Suite 102, Anchorage, AK 99503, Juneau: 225 Front Street, Suite 103-A, Juneau, AK 99801, Phone: 1-800-478-AIDS (2437), Anchorage: 907-263-2050, Juneau: 907-586-6089, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.alaskanaids.org/client-services/aids-drug-assistance-program-adap
AL	**Alabama AIDS Drug Assistance Program (ADAP),** Office of HIV Prevention and Care, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104, Phone: 1-866-574-9964, TTY: 711, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: https://www.alabamapublichealth.gov/hiv/adap.html
AR	**Ryan White Program, Arkansas AIDS Drug Assistance Program (ADAP),** 4815 W. Markham, Little Rock, AR 72205, Phone: 1-800-462-0599, Option 3, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://healthy.arkansas.gov/programs-services/topics/ryan-white-program
AZ	**Arizona AIDS Drug Assistance Program (ADAP),** 150 N.18th Ave., Suite 110, Phoenix, AZ 85007, Phone: 1-800-334-1540, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home
CA	**California AIDS Drug Assistance Program (ADAP),** P.O. Box 997377, MS 0500, Sacramento, CA 95899-7377, Phone: 1-844-421-7050, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.cdph.ca.gov/Programs/CID/DOA/pages/oaadap.aspx
CO	**Ryan White State Drug Assistance Program (SDAP),** 4300 Cherry Creek Drive South, Denver, CO 80246, Phone: 303-692-2716, TTY: 711, Hours: Monday–Friday 7:30 AM to 5:15 PM, Website: https://cdphe.colorado.gov/state-drug-assistance-program
CT	**Connecticut AIDS Drug Assistance Program (CADAP),** AIDS Project Hartford Main Office, 110 Bartholomew Ave., Third Floor, Hartford, CT 06106, Phone: 1-800-233-2503, 860-951-4833, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://portal.ct.gov/DPH/AIDS--Chronic-Diseases/Care/HIVAIDS-Services-in-Connecticut
DC	**DC AIDS Drug Assistance Program (ADAP),** 899 North Capitol Street NE, Washington, DC 20002, Phone: 202-671-4815, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, except district holidays, Website: https://dchealth.dc.gov/node/137072
DE	**Delaware AIDS Drug Assistance Program (ADAP),** Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901, Phone: 302-744-1050, Option 1, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.dhss.delaware.gov/dph/dpc/hivtreatment.html
FL	**Florida AIDS Drug Assistance Program (ADAP),** HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, Phone: 1-800-352-2437, 850-245-4422, TTY: 1-888-503-7118, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://www.floridahealth.gov/diseases-and-conditions/aids/adap/
GA	**Georgia AIDS Drug Assistance Program (ADAP),** 2 Peachtree Street NW, 15th Floor, Atlanta, GA 30303, Phone: 404-656-9805, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dph.georgia.gov/health-topics/office-hivaids/hiv-care/aids-drug-assistance-program-adap

State AIDS Drug Assistance Programs (ADAP)	
HI	**Hawaii HIV Drug Assistance Program (HDAP),** 3627 Kilauea Ave., Suite 306, Honolulu, HI 96816, Phone: 1-808-733-9360, TTY: 711, Hours: Monday–Friday 7:45 AM to 2:30 PM, Website: https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/
IA	**Iowa AIDS Drug Assistance Program (ADAP),** Lucas State Office Building, 321 E. 12th Street, Des Moines, IA 50319-0075, Phone: 515-725-2011, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://idph.iowa.gov/hivstdhep/hiv/support
ID	**Idaho AIDS Drug Assistance Program (ADAP),** 450 W. State Street, P.O. Box 83720, Boise, ID 83720-0036, Phone: 208-334-5612, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv
IL	**Illinois AIDS Drug Assistance Program (ADAP),** 525 W. Jefferson Street, 1st Floor, Springfield, IL 62761, Phone: 1-800-825-3518, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services
IN	**Indiana AIDS Drug Assistance Program (ADAP),** 2 N. Meridian Street, Indianapolis, IN 46204, Phone: 1-866-588-4948, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: https://www.in.gov/isdh/17740.htm
KS	**The Kansas Ryan White Part B Program,** Curtis State Office Building, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, Phone: 785-296-6174, Option 5, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.kdheks.gov/sti_hiv/ryan_white_care.htm
KY	**Kentucky AIDS Drug Assistance Program (KADAP),** 275 E. Main Street, HS2E-C, Frankfort, KY 40621, Phone: 1-800-420-7431, Option 1, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://chfs.ky.gov/agencies/dph/dehp/hab/pages/services.aspx
LA	**Louisiana Health Access Program (LA HAP),** 1450 Poydras Street, Suite 2136, New Orleans, LA 70112, Phone: 504-568-7474, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.lahap.org/
MA	**Massachusetts HIV/AIDS Drug Assistance Program (HDAP),** Schrafft's Center, 529 Main Street, Suite 301, Charlestown, MA 02129, Phone: 1-800-228-2714, 1-888-253-2712, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://crine.org/hdap/
MD	**Maryland AIDS Drug Assistance Program (MADAP),** 500 N. Calvert Street, 5th Floor, Baltimore, MD 21202, Phone: 1-800-205-6308, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
ME	**Maine AIDS Drug Assistance Program (ADAP),** 286 Water Street, 11 State House Station, Augusta, ME 04330, Phone: 207-287-3747, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml
MI	**Michigan HIV/AIDS Drug Assistance Program (MIDAP),** HIV Care Section, Division of Health, Wellness and Disease Control, Michigan Department of Health and Human Services, 109 Michigan Ave., 9th Floor, Lansing, MI 48913, Phone: 517-243-6734, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982-44913--,00.html

State AIDS Drug Assistance Programs (ADAP)	
MN	**Minnesota Aids Drug Assistance Program (ADAP),** Minnesota Department of Human Services, Program HH, P.O. Box 64972, St. Paul, MN 55164-0972, Phone: 1-800-657-3761, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.justushealth.org/get-support/assistance/health-insurance/program-hh
MO	**Missouri HIV/AIDS Case Management Program,** Bureau of HIV, STD, and Hepatitis, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO 65102, Phone: 573-751-6439, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
MS	**Mississippi AIDS Drug Assistance Program (ADAP),** 570 E. Woodrow Wilson Drive, Jackson, MS 39216, Phone: 1-800-826-2961, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://msdh.ms.gov/msdhsite/_static/14,13047,150.html
MT	**Montana AIDS Drug Assistance Program (ADAP),** Robert Elkins, DPHHS, P.O. Box 202951, Cogswell Building C-211, Helena, MT 59620-2951, Phone: 406-444-4744, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog#893959712-aids-drug-assistance-program-adap-services
NC	**North Carolina HIV Medication Assistance Program (NC HMAP),** NC Department of Health and Human Services Division of Public Health, Epidemiology Section Communicable Disease Branch, 1907 Mail Service Center, Raleigh, NC 27699-1907, Phone: 1-877-466-2232, 919-733-9161, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html
ND	**North Dakota AIDS Drug Assistance Program (ADAP),** North Dakota Department of Health, Division of Disease Control, 2635 East Main Ave., P.O. Box 5520, Bismarck, ND 58506-5520, Phone: 1-800-706-3448, 701-328-2378, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://ndhealth.gov/hiv/RyanWhite/
NE	**Nebraska Ryan White AIDS Drug Assistance Program (ADAP),** Nebraska Department of Health & Human Services, P.O. Box 95026, Lincoln, NE 68509-5026, Phone: 1-800-782-2437, 402-471-2101, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dhhs.ne.gov/Pages/Ryan-White.aspx
NH	**New Hampshire Ryan White CARE Program,** 29 Hazen Drive, Concord, NH 03301, Phone: 1-800-852-3345 x4502, 603-271-4502, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: https://www.dhhs.nh.gov/dphs/bchs/std/care.htm
NJ	**New Jersey AIDS Drug Distribution Program (ADDP),** P.O. Box 360, Trenton, NJ 08625-0360, Phone: 1-877-613-4533, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.state.nj.us/humanservices/doas/home/freemeds.html#addp
NM	**New Mexico AIDS Drug Assistance Program (ADAP),** Harold Runnels Building, 1190 S. St. Francis Drive, Santa Fe, NM 87505, Phone: 505-476-3628, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.nmhealth.org/about/phd/idb/hats/
NV	**Nevada AIDS Drug Assistance Program (ADAP),** Office of HIV/AIDS, 4126 Technology Way, Suite 200, Carson City, NV 89706, Phone: 702-274-2453, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://endhivnevada.org/end-hiv-nevada-program/nevadas-aids-drug-assistance-program-adap/
NY	**New York AIDS Drug Assistance Program (ADAP),** HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052, Phone: 1-800-542-2437, 1-844-682-4058, 518-459-1641, TTY: 518-459-0121, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://adap.directory/new-york

State AIDS Drug Assistance Programs (ADAP)	
OH	**Ohio HIV Drug Assistance Program (OHDAP),** 246 N. High Street, Columbus, OH 43215, Phone: 1-800-777-4775, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
OK	**Oklahoma AIDS Drug Assistance Program (ADAP),** HIV/STD Services Division, Oklahoma Department of Human Services, 1000 NE 10th Street, Mail Drop 0308, Oklahoma City, OK 73117, Phone: 405-271-4636, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://adap.directory/oklahoma
OR	**Oregon CAREAssist,** 800 NE Oregon Street, Suite 1105, Portland, OR 97232, Phone: 971-673-0144, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.oregon.gov/oha/PH/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
PA	**Pennsylvania Special Pharmaceutical Benefits Program – HIV/AIDS,** Department of Health Special Pharmaceutical Benefits Program, P.O. Box 8808, Harrisburg, PA 17105-8808, Phone: 1-800-922-9384, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
RI	**Rhode Island AIDS Drug Assistance Program (ADAP),** Executive Office of Health & Human Services, Virks Building, Suite 227, 3 West Rd., Cranston, RI 02920, Phone: 401-462-3294, 401-462-3295, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx
SC	**South Carolina AIDS Drug Assistance Program (ADAP),** SC Drug Assistance Program/ Insurance Assistance Program, 3rd Floor, Mills/Jarrett Box 101106, Columbia, SC 29211, Phone: 1-800-856-9954, 1-800-322-2437, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: https://scdhec.gov/aids-drug-assistance-program
SD	**South Dakota AIDS Drug Assistance Program (ADAP),** Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th Street, Pierre, SD 57501-1700, Phone: 1-800-592-1861, 605-773-3737, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://doh.sd.gov/diseases/infectious/ryanwhite/
TN	**Tennessee AIDS Drug Assistance Program (ADAP),** TN Department of Health, HIV/STD Program, Ryan White Part B Services, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243, Phone: 1-800-525-2437, 615-741-7500, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
TX	**Texas HIV Medication Program (THMP),** ATTN: MSJA, MC 1873, P.O. Box 149347, Austin, TX 78714-9347, Phone: 1-800-255-1090, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://dshs.state.tx.us/hivstd/meds/default.shtm
UT	**Utah Ryan White Part B ADAP AIDS Drug Assistance Program,** Utah Department of Health, Bureau of Epidemiology, 288 N 1460 West, P.O. Box 142104, Salt Lake City, UT 84114-2104, Phone: 801-538-6197, 801-538-6191, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: http://health.utah.gov/epi/treatment/
VA	**Virginia Medication Assistance Program (VA MAP),** 109 Governor Street, Richmond, VA 23219, Phone: 1-855-362-0658, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: https://www.vdh.virginia.gov/disease-prevention/vamap/

State AIDS Drug Assistance Programs (ADAP)	
VT	**Vermont Medication Assistance Program (VMAP),** 108 Cherry Street, P.O. Box 70, Burlington, VT 05402-0070, Phone: 802-951-4005, TTY: 711, Hours: Monday–Friday 7:45 AM to 3:30 PM, Website: https://www.healthvermont.gov/immunizations-infectious-disease/hiv/care
WA	**Washington Early Intervention Program (EIP),** Client Services, P.O. Box 47841, Olympia, WA 98504, Phone: 1-877-376-9316, 360-236-3426, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP
WI	**Wisconsin AIDS/HIV Drug Assistance Program (ADAP),** Division of Public Health, Attn: ADAP, P.O. Box 2659, Madison, WI 53701, Phone: 1-800-991-5532, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: https://www.dhs.wisconsin.gov/hiv/adap.htm
WV	**West Virginia AIDS Drug Assistance Program (ADAP),** Jay Adams, HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003, Phone: 304-232-6822, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: https://oeps.wv.gov/rwp/pages/default.aspx
WY	**Wyoming AIDS Drug Assistance Program (ADAP),** Wyoming Department of Health, Public Health Sciences Section Communicable Disease Unit, 6101 Yellowstone Rd., Suite 510, Cheyenne, WY 82009, Phone: 307-777-7529, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: https://adap.directory/wyoming

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State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. You will find contact information for the SHIP in your state in the Appendix of this booklet.

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