



Express Scripts®
Medicare (PDP)

Evidence of Coverage 2027

HealthSelectSM Medicare Rx Prescription Drug Plan (PDP) administered by Express Scripts[®]
Pharmacy Benefit Services provided through the Employees Retirement System of Texas (ERS)
Group Name: HealthSelect Medicare Rx
Group Number: ERSEGWP

Toll-free (866) 264-4676 (TTY: (800) 716-3231)
24 hours a day, seven days a week

[HSMedicareRx.com](https://www.HSMedicareRx.com)

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Now that you've enrolled in a Medicare Part D plan, the Centers for Medicare & Medicaid Services (CMS) requires that **Express Scripts Medicare®** (PDP) make certain plan materials available to you. This *Evidence of Coverage* includes information on standard rules and processes for a Medicare Part D prescription drug plan.

January 1 – December 31, 2027

Evidence of Coverage for 2027:

HealthSelectSM Medicare Rx Prescription Drug Plan (PDP) provided through the Employees Retirement System of Texas (ERS). This document gives you the details about your Medicare prescription drug plan coverage from January 1 – December 31, 2027. **This is an important legal document. Please keep it in a safe place.**

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

- Your Plan Premium and Cost Sharing;
- Your prescription drug benefits;
- How to file a Complaint if you're not satisfied with a service or treatment
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

For questions about this document, call Customer Service toll-free at (866) 264-4676.

Customer Service is available 24 hours a day, seven days a week. TTY users should call **(800) 716-3231**.

This Plan, HealthSelect Medicare Rx PDP, is administered by Express Scripts® Pharmacy Benefit Services. When this *Evidence of Coverage* says “we,” “us” or “our,” it means Express Scripts Medicare. When it says “the Plan” this Plan” or “your Plan,” it means HealthSelect Medicare Rx PDP.

This information is available for free in other languages, large print, and in braille. Please contact Customer Service at **(866) 264-4676** if you need Plan information in another format. Customer Service is available 24 hours a day, seven days a week and has free language interpreter services available for non-English speakers.

Esta información está disponible de forma gratuita en otros idiomas, letra grande y en braille. Comuníquese con Servicio al Cliente al **(866) 264-4676** si necesita información del Plan en otro formato. Servicio al Cliente está disponible las 24 horas del día, los 7 días de la semana y tiene servicios de interpretación gratuitos disponibles para las personas que no hablan inglés.

Benefits, Premiums (if applicable), deductibles and/or Copayments may change on January 1 of each year. The *Formulary* and/or pharmacy network may change at any time. We will notify affected enrollees about certain changes at least 30 days in advance. Limitations, Copayments and restrictions may apply. Most negative changes in coverage happen on an annual basis. See **Chapter 3, Section 6** for more information.

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Chapter 1: Getting Started as a Member

SECTION 1 Introduction

Section 1.1	You're a Member of HealthSelect Medicare Rx PDP, which is a Medicare Drug Plan
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HealthSelect Medicare Rx PDP is administered by Express Scripts[®] Pharmacy Benefit Services.

HealthSelect Medicare Rx PDP is a Medicare Part D prescription drug plan. Like all Part D plans, this prescription drug plan is approved by Medicare and administered by a private company.

Section 1.2	What is the <i>Evidence of Coverage</i> document about?
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This *Evidence of Coverage* document explains your rights and responsibilities, how to get your prescription drugs, what is covered, what you pay as a Member of the Plan, and how to file a Complaint if you're not satisfied with a decision or treatment.

The words Coverage and Covered Drugs refer to the prescription drug coverage available to you as a Member of the Plan.

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* document.

If you are confused, concerned or just have a question, please contact Customer Service at **(866) 264-4676 (TTY: (800) 716-3231)**.

Section 1.3	Legal information about the <i>Evidence of Coverage</i>
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This *Evidence of Coverage* is part of our contract with you about how HealthSelect Medicare Rx PDP covers your care. Other parts of this contract include the *Formulary (drug list)*, your *Plan Guide* and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for the months you're enrolled in HealthSelect Medicare Rx PDP between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to the Plan each calendar year. This means we can change the costs and benefits of HealthSelect Medicare Rx PDP after December 31, 2027. You will be notified of any changes that are made through the *Annual Notice of Changes* that is mailed to you at the end of the calendar year. We can also choose to stop offering the Plan in your Service Area, after December 31, 2027.

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Medicare (the Centers for Medicare & Medicaid Services, or CMS) must approve the Plan each year. You can continue each year to get Medicare coverage as a Member of the Plan as long as we continue to offer the Plan, Medicare renews its approval of the Plan, and you remain eligible for the Plan through ERS.

SECTION 2 Plan Eligibility Requirements

Section 2.1 Your Eligibility requirements

You're eligible for membership in the Plan as long as you meet all these conditions:

- You meet the eligibility requirements of ERS
- You have Medicare Part A and Medicare Part B
- You are a United States citizen or national, or an eligible noncitizen
- You live in our geographic Service Area (**Section 2.2** below describes our Service Area). Incarcerated individuals aren't considered to be living in the geographic Service Area, even if they are physically located in it.

Section 2.2 Plan Service Area for HealthSelect Medicare Rx PDP

HealthSelect Medicare Rx PDP is available only to individuals who live in the Plan Service Area. To remain a Member of the Plan, you must continue to reside in the Plan Service Area. Our Service Area includes all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

If you plan to move, please contact ERS toll-free at **(877) 275-4377, (TTY: 711)**, choose IVR prompt for “insurance” Monday through Friday, 8 a.m. to 5 p.m. CT, except major holidays.

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

Section 2.3 U.S. citizen or national, or eligible noncitizen

A Member of a Medicare prescription drug plan must be a U.S. citizen or national, or an eligible noncitizen. Medicare will notify Express Scripts Medicare if you are not eligible to remain a Member on this basis. Express Scripts Medicare must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Your Member ID card

You will receive a Member ID card. While you are a Member of the Plan, you must use your Member ID card for prescription drugs you get at In-Network pharmacies. You should also show your Medicaid card, if you have one. Below is a sample Member ID card to show you what yours will look like:

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EVERNORTH HEALTH SERVICES Express Scripts Medicare® (PDP) Prescription ID Card RxIIN 61001400 RxPCN MEDDPRIME RxGrp XXXXXXXX Issuer 9151014609 (80840) ID No. AZZA27012308 Name JOHN Q. SAMPLE Issued XX/XX/XXXX HealthSelect! Medicare Rx MedicareRx Prescription Drug Coverage CMS-S5660-801	Member Customer Service: (866) 264-4676 TTY Users: (800) 716-3231 Web: HSMedicareRx.com Pharmacist Use Only: (800) 922-1557
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Please carry your card with you at all times and remember to show your card when you get Covered Drugs. If your Member ID card is damaged, lost or stolen, call Customer Service at **(866) 264-4676** right away and we will send you a new card. You must either show your Member ID card to an In-Network Pharmacy at the time you obtain your prescription or you must provide the Medicare Beneficiary Identifier (MBI) found on your red, white and blue Medicare ID card or your 9-digit Social Security Number to verify your enrollment in the Plan.

If you don't show your Member ID card or provide verifiable information at an In-Network Pharmacy, you will be required to pay the usual and customary charge for the prescription drug at the In-Network Pharmacy.

You may request reimbursement as described in **Chapter 5, Section 2**. However, when you submit a claim in this manner, you may pay more if you failed to verify your eligibility at the time the prescription drug was dispensed.

You will need to use your medical coverage ID card to get covered medical care, services or Part B prescription drugs including some vaccines.

Section 3.2 Pharmacy Directory

The most up-to-date pharmacy network information is available to you on our website at **HSMedicareRx.com**.

You can also request a copy of the printed *Pharmacy Directory*, which gives you a list of the In-Network retail pharmacies closest to you — that means the pharmacies in your area that have agreed to fill prescription drugs for Plan Members — as well as other pharmacies (such as long-term care pharmacies) in our network. You can use the *Pharmacy Directory* to find the In-Network Pharmacy you want to use. See **Chapter 3, Section 2.4** for information on when you can use pharmacies that aren't in the Plan's network.

With few Exceptions, you must get your prescriptions filled at one of our In-Network pharmacies if you want the Plan to cover (help you pay for) them.

The *Pharmacy Directory* will also tell you which pharmacies in our network provide up to a 90-day supply, and which pharmacies only dispense a one-month supply. You can also use our home delivery service that will fill prescriptions for more than a one-month supply.

If you don't have a *Pharmacy Directory*, you can call Customer Service at **(866) 264-4676** to request a copy or visit our website at **HSMedicareRx.com**.

Chapter 1**Section 3.3 The Plan's *Formulary* (drug list)**

The most up-to-date *Formulary* (drug list) is available to you on our website at **HSMedicareRx.com**. You can also request that we mail you a copy of the printed *Formulary*. We call it the drug list for short. The printed *Formulary* contains a listing of the most commonly prescribed prescription drugs that are covered under the Part D benefit included in HealthSelect Medicare Rx PDP. The prescription drugs and supplies on this list are selected by the Plan, with the help of doctors and pharmacists. The drug list meets all requirements set by Medicare. Medicare has approved the HealthSelect Medicare Rx PDP drug list.

The drug list also shows any rules that restrict coverage for prescription drug, and it includes information for the prescription Drugs that are most commonly used by our Members. However, we may cover additional Part D drugs that are not included in the printed drug list. If one of your prescription drugs is not listed in the drug list, you can visit our website at **HSMedicareRx.com** to get the most complete and current information about which drugs are covered or contact HealthSelect Medicare Rx PDP Customer Service at **(866) 264-4676** to find out if we cover it.

SECTION 4 Summary of Important Costs for 2027

Your costs may include the following:

- Plan Premium (**Section 4.1**)
- Monthly Medicare Part B Premium (**Section 4.2**)
- Part D Late Enrollment Penalty (LEP) (**Section 4.3**)
- Income-Related Monthly Adjusted Amount (**Section 4.4**)
- Medicare Prescription Payment Plan (**Section 4.5**)

Section 4.1 Your monthly Premium for HealthSelect Medicare Rx PDP

Please contact ERS toll-free at **(877) 275-4377 (TTY: 711)** for any information about Premiums for this Plan and if they apply to you. 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).

In some situations, your Plan Premium could be less

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. **Chapter 2, Section 7** tells more about these programs. If you qualify, enrolling in one or both of these programs might lower your monthly Plan Premium.

If you are *already* enrolled and getting help from one of these programs, **the information about Premiums in this Evidence of Coverage may not apply to you.** We will send you a separate notice, called “*Important Information for Those Who Receive Extra Help Paying for Their 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 notice, please call Customer Service at **(866) 264-4676** and ask for the *LIS Rider*.

Medicare Part B and Part D Premiums differ for people with different incomes. If you have questions about these Premiums, review your copy of the *Medicare & You 2027* handbook, the section called “2027 Medicare Costs.” If you need a copy, you can download it from the Medicare website ([Medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you)). Or, you can order a printed copy by phone at (800) MEDICARE ((800) 633-4227), 24 hours a day, seven days a week. TTY users call (877) 486-2048.

Section 4.2 Monthly Medicare Part A and B Premiums

Some Members are required to pay other Medicare Premiums

You must continue paying your Medicare Premiums to remain a Member of the Plan. This includes your Premium for Part B (unless your Part B Premium is paid for you by Medicaid or another third party). You may also pay a Premium for Part A, if you aren't eligible for Premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty (LEP)

Some Members are required to pay a Part D **late enrollment penalty (LEP)**. The Part D LEP is an additional Premium that must be paid to have Part D coverage if at any time after your Initial Enrollment Period was over, there was a period of 63 days or more in a row when you didn't 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 drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other Creditable Prescription Drug Coverage. You'll have to pay this penalty for as long as you have Part D coverage.

ERS has elected to pay your late enrollment penalty while you are enrolled in the HealthSelect Medicare PDP. However, if you join another plan your late enrollment penalty may not be covered and you may be responsible for paying your late enrollment penalty.

You **don't** have to pay it if:

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

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

If you went 63 days or more without Part D or other Creditable Prescription Drug Coverage after your Initial Enrollment Period, the Plan will count the number of full months you didn't have coverage.

- Then Medicare determines the amount of the average monthly Premium for Medicare drug plans in the nation from the previous year. For 2027, this average Premium amount is \$41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary Premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage,

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the penalty percentage would be 14% times \$41.33, which equals \$5.78. This rounds to a penalty amount of \$5.80. This amount would be added **to the monthly Premium for someone with a Part D LEP**.

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

- **The penalty may change each year** because the average monthly Premium can change each year.
- **You will generally continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you are under 65 and enrolled in Medicare, the Part D LEP will reset when you turn 65. After age 65, your Part D LEP will be based only on the months you don't have coverage after your Initial Enrollment Period for aging into Medicare.

If you disagree about your Part D LEP, you or your representative can ask for a reconsideration (Appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a LEP. However, if you were paying a penalty before you joined the Plan, you will not have another chance to ask for a review of that LEP.

Section 4.4	Income-Related Monthly Adjustment Amount
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Some Members may be required to pay an extra charge, known as the Part D Income-Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard Premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit [Medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans](https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans).

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

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

Chapter 1**Section 4.5 Medicare Prescription Payment Plan Amount**

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your Plan Premium (if you have one) and you'll get a bill from your drug plan for your prescription drugs (instead of paying the pharmacy). We calculate your first month's bill differently than your bill for the rest of the year. Please be aware that your monthly payment will vary depending on what month you elect into the program and your monthly Out-of-Pocket costs.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 7** to make a Complaint or Appeal. Please note: This is an optional payment plan that may help you manage your expenses, but does not save you money or lower your drug costs. To find out if this payment plan is right for you call Customer Service at **(866) 264-4676**.

SECTION 5 More information about your monthly Premium**Your monthly Plan Premium won't change during the year**

ERS is not allowed to change the Premium amount for the Plan's monthly Plan Premium during the year. If the monthly Plan Premium changes for next year, you'll be notified in the fall and the new Premium will take effect on January 1.

If you become eligible for the Extra Help program or lose your eligibility for Extra Help during the year, the part of your Plan Premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly Plan Premiums. If you lose your eligibility during the year you'll need to start paying the full monthly Premium. Find out more about Extra Help in **Chapter 2, Section 7**.

SECTION 6 Keep your contact information up to date

ERS provides Express Scripts Medicare with your enrollment information, including your address and phone number. We create a membership record using that information.

The providers in the Plan's network use your membership record to know what drugs are covered and the Cost-Sharing amounts for you. Because of this, it is very important you help to keep your information up to date.

Contact ERS at **(877) 275-4377 (TTY: 711)** from 8 a.m. – 5 p.m. CT, Monday – Friday if you have the following updates for your account:

- Changes to your name, address or phone number

Contact HealthSelect Medicare Rx PDP Customer Service at (866) 264-4676 for these changes:

- Changes in any other health coverage you have (such as from your employer, your spouse or common law spouse's employer, Workers' Compensation or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home

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- If your designated responsible party (such as a caregiver) changes

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at (800) 772-1213 (TTY users call (800) 325-0778).

SECTION 7 How other insurance works with the Plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under the Plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at **(866) 264-4676**. You may need to give your Plan Member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

These rules apply for employer or retiree group health plan coverage (other coverage outside this Plan):

- 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) are 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 has more than 100 employees.
 - If you're over 65 and you (or your spouse or common law spouse) are 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 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

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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 questions about who pays first, or you need to update your other insurance information, call Customer Service at **(866) 264-4676**.

CHAPTER 2:

Phone numbers and resources

SECTION 1 HealthSelect Medicare Rx PDP contacts

For assistance with claims, billing, or HealthSelect Medicare Rx PDP Member ID card questions, call or write to HealthSelect Medicare Rx PDP Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
Call	(866) 264-4676 Customer Service is available 24 hours a day, seven days a week. Customer Service also has free language interpreter services available for non-English speakers.
Write	Express Scripts Medicare P.O. Box 66535 St. Louis, MO 63166-6535
Website	HSMedicareRx.com

How to ask for a coverage decision or Appeal

A coverage decision is a review process to determine if a prescription drug or supply is covered under the HealthSelect Medicare Rx PDP or about the amount we pay for your Part D drugs. An Appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on how to ask for coverage decisions or Appeals about your Part D drugs, go to **Chapter 7**.

Coverage Reviews for Part D Prescription Drugs – Contact Information	
Call	(844) 374-7377 Calls to this number are free. Our business hours are 24 hours a day, seven days a week.
TTY	(800) 716-3231 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, seven days a week.
Fax	(877) 251-5896
Write	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571
Website	HSMedicareRx.com

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Appeals for Part D Prescription Drugs – Contact Information	
Call	(844) 374-7377 Calls to this number are free. Our business hours are 24 hours a day, seven days a week.
TTY	(800) 716-3231 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, seven days a week.
Fax	(877) 852-4070
Write	Express Scripts Attn: Medicare Appeals P.O. Box 66588 St. Louis, MO 63166-6588
Website	HSMedicareRx.com

How to make a Complaint

You can make a Complaint about us or one of our In-Network pharmacies, including a Complaint about the quality of your care.. For more information on how to make a Complaint, go to **Chapter 7**.

Complaints – Contact Information	
Call	(866) 264-4676 Calls to this number are free.
TTY	(800) 716-3231 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, seven days a week.
Fax	(800) 293-2192
Write	Express Scripts Medicare Attn: Grievance Resolution Team P.O. Box 5003 Hartford, CT 06102
Medicare Website	You can submit a Complaint about HealthSelect Medicare Rx PDP directly to Medicare, go to Medicare.gov/MedicareComplaintForm/home.aspx .

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

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

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

Payment Requests – Contact Information	
Call	(866) 264-4676 Calls to this number are free.
Fax	(608) 741-5483
Write	Express Scripts ATTN: Medicare Part D P.O. Box 52023 Phoenix, AZ 85072
Website	HSMedicareRx.com

SECTION 2 Get Help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with companies that offer Medicare Prescription Drug Plans, including this Plan.

Medicare – Contact Information	
Call	(800) MEDICARE, or (800) 633-4227 Calls to this number are free, 24 hours a day, seven days a week.
TTY	(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.
Chat Live	Chat live at Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly wellness visits). • Get Medicare Appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. You can also visit Medicare.gov to tell Medicare about any Complaints you have about Express Scripts Medicare. To submit a complaint to Medicare, go to Medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Please refer to the SHIP listing located in the **Appendix** to find information about the SHIP in your state.

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

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 straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare Plan choices and answer questions about switching Plans. Visit shiphelp.org (Click on SHIP LOCATOR in middle of page).

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves beneficiaries with Medicare in each state. Please refer to the QIO listing located in the **Appendix** to find information about the QIO in your state.

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

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

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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

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Social Security – Contact Information	
Call	(800) 772-1213 Calls to this number are free. Call between 8:00 a.m. and 7:00 p.m., Monday through Friday to speak with a representative. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	(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 8:00 a.m. to 7:00 p.m., Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare Premiums. These **Medicare Savings Programs** include:

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

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

SECTION 7 Programs to help people pay for prescription drugs

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

Extra Help from Medicare

Medicare and Social Security have a program Extra Help that can help to pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan’s monthly Premium, yearly deductible, and Copayments. Extra Help also counts toward your Out-of-Pocket costs.

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If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you may be able to get Extra Help to pay for your prescription drug Premiums and costs. To see if you qualify for getting Extra Help:

- Visit secure.ssa.gov/i1020/start to apply online.
- Call Social Security at (800) 772-1213. TTY users call (800) 325-0778.

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

You will receive information on the Extra Help that you qualify for and what you can expect to pay for your prescription. If you think that you are being charged the incorrect amount, contact **(866) 264-4676** (TTY: **(800) 716-3231**) for further assistance.

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

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

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

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

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

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

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

Fax: (855) 297-7271
Address: Express Scripts Medicare (PDP)
P.O. Box 4558
Scranton, PA 18505

When we get the evidence showing the right Copayment level, we'll update our system so you can pay the right Copayment when you get your next prescription at the pharmacy. If you overpay your Copayment, we'll pay you back either by check or a future Copayment credit. If the pharmacy didn't collect your Copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Service at (866) 264-4676 if you have questions.

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug Plan Premiums and/or other drug costs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access to life-saving HIV medications. Medicare Part D drugs that are also on the ADAP *Formulary* qualify for prescription Cost-Sharing help in those states that have this program.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, Prescription drugs, or how to enroll in the program, refer to the contact information located in the **Appendix**.

State Pharmaceutical Assistance Programs

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

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is payment option that works with your current Part D drug coverage to help you manage your out-of-pocket costs for Part D drugs covered by the Plan. This payment option spreads your drug costs across monthly payments that may change throughout the remainder of the plan year (January – December). Anyone with a Medicare drug plan can use this payment option.

If you elect to join the Medicare Prescription Payment Plan, please be aware that your monthly payment will vary depending on what month you elect into the program and your monthly Out-of-Pocket costs. Your first month will be calculated differently than your remaining months of the year. Even if this payment option might help you manage your expenses, it doesn't save you money or lower your drug costs. Extra Help from Medicare and help from your SPAP and ADAP are programs that can lower cost shares for those who qualify. To contact the SPAP or ADAP program(s) that may be available in your state, please see the **Appendix**.

If you're currently participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027. If you don't want to participate in the Medicare Prescription Payment Plan, you can disenroll at any time. To disenroll, please contact us at (866) 845-1803 24 hours a day, seven days a week. TTY users call (800) 716-3231 or visit Medicare.gov.

To learn more about this payment option, or for detailed examples of how to calculate what your payments might be, visit one of these online resources: [Medicare.gov/prescription-payment-plan](https://www.medicare.gov/prescription-payment-plan) **or the Resources section of HSMedicareRx.com.**

You may also call Express Scripts Medicare at (866) 264-4676 for assistance. See the next page for additional contact information.

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Medicare Prescription Payment Plan – Contact Information	
Call	(866) 264-4676
TTY	(800) 716-3231 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, seven days a week.
Write	Express Scripts Medicare Prescription Payment Plan P.O. Box 2 St. Louis, MO 63166 This address is only to be used for general inquiries.
Website	express-scripts.com/mppp or Medicare.gov

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board – Contact Information	
Call	(877) 772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12:00 p.m. on Wednesday. Press “1” to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	(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 aren't free.
Website	RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or common law spouse) are eligible to get benefits from ERS, you may call ERS if you have any questions. You can ask about your (or your spouse or common law spouse's) retiree health benefits, Premiums, or the enrollment period. The phone number for Customer Service is **(866) 264-4676**.

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You may also call (800) MEDICARE (800) 633-4227; TTY: (877) 486-2048 with questions related to your Medicare coverage under the Plan.

If you have other prescription drug coverage through a different employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you understand how your current drug coverage will work with this Plan.

CHAPTER 3: Using the Plan's coverage for Part D prescription drugs

SECTION 1 Basic rules for this Plan's Part D drug coverage

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

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

The two examples of drugs described above are covered by Original Medicare or your medical plan. (To find out more about this coverage, go to your *Medicare & You 2027* handbook.) Your Part D prescription drugs are covered under the Plan.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use an In-Network Pharmacy to fill your prescription. See **Section 2**, in this chapter. Or you can fill your prescription at an In-Network Pharmacy or through Express Scripts Pharmacy, our mail order pharmacy.
- Your drug must be on the Plan's drug list. (Go to **Section 3**, *The Plan's drug list*.) To get the most current information, visit the Plan's website at **HSMedicareRx.com**.
- Your drug must be used for a Medically Accepted Indication. A Medically Accepted Indication is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain references. (Go to **Section 3**, *The Plan's drug list*, for more information about a Medically Accepted Indication.)
- Your drug may require approval from the Plan based on certain criteria before we agree to cover it. (Go to **Section 4** for more information.)

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SECTION 2 Fill your prescription at an In-Network Pharmacy or through Express Scripts[®] Pharmacy home delivery service

In most cases, your prescriptions are covered *only* if they're filled at the Plan's In-Network pharmacies. (Go to **Section 2.4** for information about when we cover prescriptions filled at Out-of-Network pharmacies.)

An In-Network Pharmacy is a pharmacy that has a contract with the Plan to provide your prescription drugs. The term Covered Drugs means all the Part D drugs that are on the Plan's drug list.

Section 2.1 In-Network pharmacies

Find an In-Network Pharmacy in your area

To find an In-Network Pharmacy, visit our website at **HSMedicareRx.com** or call Customer Service at **(866) 264-4676**.

You may go to any of our In-Network pharmacies. If you switch from one In-Network Pharmacy to another and you need a refill of a drug you've been taking, you can ask to have a new prescription written by a provider or to have your prescription transferred to your new In-Network Pharmacy.

If your pharmacy leaves the network?

If the pharmacy you use leaves the Plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, call Customer Service at **(866) 264-4676** or use the *Pharmacy Directory*. You can also find information on our website at **HSMedicareRx.com**.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Customer Service at **(866) 264-4676**.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, visit our website at **HSMedicareRx.com**, call Customer Service at **(866) 264-4676** or check your *Pharmacy Directory*.

Section 2.2	Express Scripts Pharmacy home delivery service (also called mail-order drugs)
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When we refer to home delivery or mail-order drugs in this document, we are referring to prescriptions filled by the Plan's home delivery service through Express Scripts Pharmacy. For certain kinds of prescription drugs, you can use the Plan's home delivery service from Express Scripts Pharmacy. Generally, the prescription drugs provided through Express Scripts Pharmacy are drugs you take on a regular basis for a chronic or long-term medical condition. The drugs available through the Plan's home delivery service are marked as **mail-order drugs (MO)** in our drug list.

The Plan's home delivery service generally allows you to order prescriptions for **more than a one-month supply**. **The Plan's Mail Order Pharmacy does not fill prescriptions for less than a 30-day supply.**

There are other pharmacies in our network that will provide your prescriptions by mail. The information that follows may not apply to these pharmacies. You should contact these other pharmacies directly to understand their rules and processes. To locate these pharmacies, visit **HSMedicareRx.com** or call Customer Service at **(866) 264-4676**.

To get order forms and information about filling your prescriptions by mail, either visit our website at **HSMedicareRx.com** and scroll down to Home Delivery to download our order form or call Customer Service at **(866) 264-4676**.

Usually, a home delivery pharmacy order from Express Scripts Pharmacy will get to you within 10 days. However, sometimes your home delivery may be delayed. Make sure you have at least a 14-day supply of medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a one-month supply and fill it at an In-Network retail pharmacy while you wait for your home delivery supply to arrive. If your home delivery shipment from Express Scripts Pharmacy is delayed, please call Customer Service at **(866) 264-4676**.

Refills on home delivery prescriptions from Express Scripts Pharmacy. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, we start to process your next refill automatically when our records show you should be close to running out of your drug. Express Scripts Medicare will contact you before shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the home delivery pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares home delivery refills, please contact us by visiting our website at **HSMedicareRx.com** or by calling Customer Service at **(866) 264-4676**. You should also provide the best ways to contact you by calling Customer Service at **(866) 264-4676**. This way, the pharmacy can reach you to confirm your order before shipping.

If you get a refill automatically by mail that you don't want you may be eligible for a refund.

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New prescriptions Express Scripts Pharmacy gets directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it gets from healthcare providers, without checking with you first, if either:

- You used mail-order services with this Plan in the previous 12 months, or
- You sign up for automatic delivery of all new prescriptions received directly from healthcare providers. You can ask automatic delivery of all new prescriptions at any time by contacting Customer Service at **(866) 264-4676**. The request for automatic deliveries of new prescriptions only lasts until the end of the plan year (which is the last day of the calendar year), and you must submit a new request every year and/or each time you change plans.

Please note that not all prescriptions are eligible for automatic delivery. Medications commonly excluded from the program include those not indicated for chronic use (antibiotics, anti-infectives) or prescribed on an as-needed basis (pain medications), as well as medications with legal restrictions or supply limitations and controlled substances.

If you get a prescription automatically by mail that you don't 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 home delivery in the past and don't want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Service at **(866) 264-4676**.

If you never used our home delivery service and/or decide to stop automatic fills of new prescriptions, Express Scripts Pharmacy will contact you each time it gets a new prescription from a healthcare provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay or cancel the new prescription.

Section 2.3	How to get a long-term supply of maintenance drugs
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To find an In-Network Pharmacy, visit our website at **HSMedicareRx.com** or call Customer Service at **(866) 264-4676**.

When you get an extended day supply of drugs, your Cost Sharing may be lower. The Plan offers three ways to get an Extended Day Supply (EDS) of maintenance drugs on the Plan's drug list. Maintenance drugs are drugs you take regularly to treat a chronic or long-term medical condition. You may order this supply through EDS network pharmacies or through the Express Scripts Pharmacy mail-order pharmacy, described above, or through other home delivery pharmacies in our network.

1. Some retail pharmacies in our network are part of the EDS network and allow you to get an extended day supply of maintenance drugs at the same price you'd pay at the Plan's mail order pharmacy. Your *Pharmacy Directory* tells you which pharmacies in our network can give you an extended day supply of maintenance drugs. You can also call Customer Service at **(866) 264-4676** for more information.
2. For certain kinds of maintenance drugs, you can use the Plan's **mail order service, Express Scripts Pharmacy. The drugs available through the Plan's home delivery service are marked as "MO" drugs in our drug list.**

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Go to **Section 2.2** for more information about using our home delivery service. The Plan's home delivery service allows you to order more than a one-month supply.

3. Other home delivery pharmacies may have their own policies regarding prescriptions by mail. We suggest that you contact those pharmacies directly for any requirements they may have.

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

Your cost may be greater if you use an Out-of-Network Pharmacy to fill your prescription. If you use an Out-of-Network Pharmacy, you must pay for the prescription out of pocket and submit a paper claim in order to be reimbursed.

Generally, we cover drugs filled at an Out-of-Network Pharmacy *only* when you aren't able to use an In-Network Pharmacy. **Please check first with Customer Service at (866) 264-4676 to see if there's an In-Network Pharmacy nearby.**

If you must use an Out-of-Network Pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to **Chapter 5, Section 2** for more information on how to ask the Plan to pay you back.) Please note that you will only receive reimbursement if the drug is a Covered Drug or Supply and reimbursement will be at the network rate.

We cover prescriptions filled at an Out-of-Network Pharmacy only in these circumstances:

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

When traveling. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill, lose, or run out of your covered medications, we will cover prescriptions that are filled at an Out-Of-Network Pharmacy if you follow all other coverage rules. Prior to filling your prescription at an Out-Of-Network Pharmacy, call Customer Service at **(866) 264-4676** to find out if there is an In-Network Pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an Out-Of-Network Pharmacy. The HealthSelect Medicare Rx PDP does not cover or offer reimbursement for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

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

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

If you were a patient in an emergency department or other outpatient facility. While you are in a hospital or an outpatient facility for an observation stay, the hospital or outpatient facility will most likely administer the drugs you take at home on a daily basis. These are also called Self-Administered Drugs

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(SAD). You will need to ask for reimbursement for the SAD drugs and they will be covered as Out-of-Network.

If you received a vaccine at your doctor's office or pharmacy. You will need to ask for reimbursement for a Medicare Part D vaccine administered by your doctor or Out-of-Network Pharmacy. Note that the Plan does not cover or reimburse for administration fees.

In these situations, **please check first with HealthSelect Medicare Rx PDP Customer Service at (866) 264-4676** to see if there is an In-Network Pharmacy nearby. Your cost may be greater if you use an Out-of-Network Pharmacy.

SECTION 3 The Plan's drug list

Section 3.1 The drug list tells which Part D drugs are covered
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The Plan has a *Formulary (List of Covered Drugs)*. In this *Evidence of Coverage*, **we call it the drug list for short.**

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

The drugs on the drug list include those covered under Medicare Part D and some additional drugs that the Plan covers. Drugs that are covered through this additional coverage are referred to as Enhanced Drugs and are marked as "ENC" on the drug list. Please note that the drug list does not include all of the Enhanced Drugs covered by this plan. If one of your drugs is not listed on the drug list, you should visit **HSMedicareRx.com** or call Customer Service at **(866) 264-4676**.

We generally cover a drug on the Plan's drug list as long as you follow the other coverage rules explained in this chapter and use of the drug is for a Medically Accepted Indication. A Medically Accepted Indication is a use of the drug that is *either*:

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

The drug list includes Brand-name drugs, Generic Drugs, and Biological Products (which may include Biosimilars).

A Brand-name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer.

A Generic Drug is a prescription drug that has the same active ingredients as the Brand-name drug.

Biological Products are drugs that are more complex than typical drugs. On the drug list, when we refer to "drugs," this could mean a drug or a Biological Product. Biological Products have alternatives called Biosimilars.

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Generally, generics and Biosimilars work just as well as the Brand-name drug or Original Biological Product and usually cost less. There are Generic Drug substitutes available for many Brand-name drugs and Biosimilar alternatives for some Original Biological Products. Some biosimilars are interchangeable Biosimilars and, depending on state law, may be substituted for the Original Biological Product at the pharmacy without needing a new prescription, just like Generic Drugs can be substituted for Brand-name drugs.

Go to **Chapter 10** for definitions of types of drugs that may be on the drug list.

Drugs that aren't on the drug list

The Plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare Plan to cover certain types of drugs. (For more information, go to **Section 7**.)
- In other cases, we decided not to include a particular drug on the drug list.
- In some cases, you may be able to obtain a drug that is not on the drug list. (For more information, go to **Section 7**.)

Section 3.2 There are three Cost-Sharing Tiers for drugs on the drug list

Every 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:

Your other plan materials have more information about your Plan's coverage stages and list the specific cost-sharing amounts for each tier.

Drug Tiers Tier	Includes	Helpful tips
Tier 1: Generic Drugs	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	Use Tier 1 drugs for the lowest Cost-Sharing amount.
Tier 2: Preferred Brand Drugs	This tier includes preferred Brand-name drugs.	Drugs in this tier will generally have lower Cost-Sharing amounts than non-preferred drugs.
Tier 3: Non-Preferred Drugs	This tier includes non-preferred Brand-name drugs.	Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred Brand-name drug may be right for you.

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To find out which Cost-Sharing Tier your drug is in, look it up in the Plan's drug list.

The amount you pay for drugs in each Cost-Sharing Tier is shown in **Chapter 4** (*What you pay for Part D drugs*).

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

To find out if a drug is on the drug list, you have these options:

1. Visit the Plan's website at **HSMedicareRx.com**. Click **Price a Medication**. The drug list on the website is always the most current.
2. Call Customer Service at **(866) 264-4676** to find out if a particular drug is covered by the Plan.
3. Check the drug list online at **HSMedicareRx.com**. (Please note: We may cover additional drugs that aren't included in the printed drug list. If one of your drugs isn't listed visit our website or contact Customer Service at **(866) 264-4676** to find out if we cover it.)
4. Use the Plan's **Price a Medication** (log in at **HSMedicareRx.com**, or by calling Customer Service at **(866) 264-4676**). With this tool you can see if a medication is covered. Search for drugs on the drug list to get an estimate of what you'll pay and see if there are alternative drugs on the drug list that could treat the same condition.

SECTION 4 Drugs with restrictions on coverage**Section 4.1 Why some drugs have restrictions**

For certain prescription drugs, special rules restrict how and when the Plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the safest and most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the drug list. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the Plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps in order for us to cover the drug. Call Customer Service at **(866) 264-4676** to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to **Chapter 7**.)

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Getting Plan approval in advance

For certain drugs, you or your provider need to get approval from the Plan based on specific criteria before we agree to cover the drug for you. This is called **Prior Authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by the Plan. The Plan's prior authorization criteria can be obtained by calling Customer Service at **(866) 264-4676** or visiting the Plan's website at **HSMedicareRx.com**.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the Plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the Plan may require you to try Drug A first. If Drug A doesn't work for you, the Plan will then cover Drug B. This requirement to try a different drug first is called **Step Therapy**. The Plan's Step Therapy criteria can be obtained by calling Customer Service at **(866) 264-4676** or visiting the Plan's website at **HSMedicareRx.com**.

Quantity limits

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

What is a compounded drug?

A compounded drug is created by a pharmacist by combining or mixing ingredients to create a prescription medication customized to the needs of an individual patient.

Does my Part D Plan cover compounded drugs?

Generally compounded drugs are non-formulary drugs (not covered) by the Plan. You may need to ask for and receive an approved Coverage Determination from us to have your compounded drug covered. Compounded drugs may be Part D eligible if they meet all of the following requirements:

1. Contains at least one FDA, or Compendia, approved drug ingredient, and all ingredients in the compound (including their intended route of administration) are supported in the Compendia.
2. Does not contain a non-FDA approved or Part D excluded drug ingredient
3. Does not contain an ingredient covered under Part B. (If it does, the compound may be covered under Part B rather than Part D.)
4. Prescribed for a medically accepted condition

The chart on the next page explains the basic requirements for how a compound with 2 or more ingredients may or may not be covered under Part D rules, as well as potential costs to you.

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Compound Type	Medicare Coverage
Compound containing a Part B eligible ingredient	Compound is covered only by Part B
Compound containing all ingredients eligible for Part D coverage and all ingredients are approved for use in a compound	Compound may be covered by Part D upon approved Coverage Determination
Compound containing ingredients eligible for Part D coverage and approved for use in a compound, and ingredients excluded from Part D coverage (for example, over-the-counter drugs, etc.)	Compound may be covered by Part D upon approved Coverage Determination. However, the ingredients excluded from Part D coverage will not be covered and you are not responsible for the cost of those ingredients excluded from Part D coverage.
Compound containing an ingredient not approved or supported for use in a compound	Compound is not covered by Part D. You are responsible for the entire cost.

What do I have to pay for a covered compounded drug?

A compounded drug that's Part D eligible may require an approved Coverage Determination to be covered by the Plan. You will pay the non-preferred drug Copay amount for compounded drugs that are approved. No further tier cost share reduction is allowed or available.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take isn't on our *Formulary* (drug list) or is on our *Formulary* with restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the Brand-name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage
- The drug is covered, but in a Cost-Sharing Tier that makes your Cost Sharing more expensive than you think it should be.

If your drug is in a Cost-Sharing Tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

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You may be able to get a temporary supply

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

To be eligible for a temporary supply, the drug you take **must no longer be covered by the Plan or is now restricted in some way.**

- **If you're a new Member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in the Plan.
- **If you were in the Plan last year**, we'll cover a temporary supply of your drug during the first 90 days of the calendar year if you have previously taken the drug within the Plan's look back period. This look back period ranges between 108 and 365 days.
- This temporary supply will be for a maximum of a one-month supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a one-month supply of medication. The prescription must be filled at an In-Network Pharmacy. (Please note that a long-term care pharmacy may provide a drug in smaller amounts at a time to prevent waste.)
- **For Members who've been in the Plan for more than 90 days and live in a long-term care (LTC) facility and need a supply right away:**

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

Current Members with Level of Care Changes: Other times when we'll cover at least a temporary 30-day transition supply (or less if you have a prescription written for fewer days) include:

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

For questions about a temporary supply, call Customer Service at **(866) 264-4676**.

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

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by the Plan may work just as well for you. Call Customer Service at **(866) 264-4676** to ask for a list of Prescription Drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an Exception

You and your provider can ask the Plan to make an Exception and cover the drug in the way you'd like it covered. If your provider says that you have medical reasons that justify asking us for an Exception,

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your provider can help you ask for an Exception. For example, you can ask the Plan to cover a drug that is not currently covered. Or you can ask the Plan to make an Exception and cover the drug without restrictions.

If you are a current Member and a drug you take will be removed from the *Formulary* or restricted in some way for next year, we'll tell you about any change prior to the new year. You can ask for an Exception before next year and we'll give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we'll authorize the coverage before the change takes effect.

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

Section 5.1	What to do if your drug is in a Cost-Sharing tier you think is too high
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If your drug is in a Cost-Sharing Tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a Cost-Sharing Tier you think is too high, talk to your provider. There may be a different drug in a lower Cost-Sharing Tier that might work just as well for you. Call Customer Service at **(866) 264-4676** to ask for a list of Covered Drugs that treat the same medical condition. This list can help your provider find a Covered Drug that might work for you.

You can ask for an Exception

You and your provider can ask the Plan to make an Exception in the Cost-Sharing Tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an Exception, your provider can help you ask for an Exception to the rule.

If you and your provider want to ask for an Exception, **Chapter 7, Section 5.4** tells you 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 **The Drug List can change during the year**

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

- **Add or remove drugs from the drug list.** New drugs become available during the year, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled or it is no longer available. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower Cost-Sharing Tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a Brand-name drug with a generic drug.**

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- **Replace an Original Biological Product with an interchangeable Biosimilar version of the Biological Product.**

We must follow Medicare requirements before we change the Plan's drug list.

Information on changes to drug coverage

When changes to the drug list occur, we post information on our website about those changes. We also update our online drug list regularly. If the change will negatively affect you, we'll send you a letter. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the drug list and immediately removing or making changes to a like drug on the drug list.**
 - When adding a new version of a drug to the drug list, we may immediately remove a like drug from the drug list, move the like drug to a different Cost-Sharing Tier, add new restrictions, or both. The new version of the drug will be on the same or a lower Cost-Sharing Tier and with the same or fewer restrictions.
 - We'll make these immediate changes only if we add a new generic version of a Brand-name drug or add certain new Biosimilar versions of an Original Biological Product that was already on the drug list.
 - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the drug list and removing or making changes to a like drug on the drug list**
 - When adding another version of a drug to the drug list, we may remove a like drug from the drug list, move it to a different Cost-Sharing Tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower Cost-Sharing Tier and with the same or fewer restrictions.
 - We'll make these changes only if we add a new generic version of a Brand-name drug or add certain new Biosimilar versions of an Original Biological Product that was already on the drug list.
 - We'll tell you at least 30 days before we make the change or tell you about the change and cover a one-month supply of the drug you're taking.
- **Removing unsafe drugs and other drugs on the drug list that are withdrawn from the market.**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the drug list. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the drug list.**
 - We may make other changes once the year has started that affect drugs you take. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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- We'll tell you at least 30 days before we make these changes or tell you about the change and cover a one-month supply of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an Exception to continue covering the drug or version of the drug you've been taking. For more information on how to ask for a coverage decision, including an Exception, go to **Chapter 7**.

Changes to the drug list that don't affect you during this plan year

We may make certain changes to the drug list that aren't described above. In these cases, the change won't apply if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in this Plan. For example, we might add a Generic Drug that is not new to the market to replace a Brand-name drug or interchangeable Biosimilar on the drug list or change the Cost-Sharing Tier or add new restrictions to the Brand-name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher Cost-Sharing Tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the drug list.

If any of these changes happen for a drug you take (except for market withdrawal, a Generic Drug replacing a Brand-name drug, or other changes noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you won't see any increase in your payments or any added restrictions on your use of the drug.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the drug list for the next plan year (when the list is available during the fall enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs not covered

Some kinds of prescription drugs are excluded according to Medicare's rules. This means Medicare will not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. Some Part D excluded drugs are covered under the Plan's enhanced coverage. If you Appeal and the requested drug is found not to be excluded under Part D and you meet the coverage criteria, the Plan will pay for or cover it. (For information about Appealing a decision, go to **Chapter 7**.)

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

- The Plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.

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- The Plan can't cover a drug purchased outside the United States or its territories.
- The Plan can't cover off-label use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Please note: ERS **may** have elected to offer some of the drugs listed above to you as an additional benefit. If so, you will receive additional information about the drugs they have chosen to offer to you separately, in the drug list.

If you get **Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for the drugs that aren't normally covered. (Go to the Plan's drug list or call Customer Service at **(866) 264-4676** for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in the **Appendix**.)

SECTION 8 How to fill a prescription

To fill your prescription, show your HealthSelect Medicare Rx PDP Member ID card at the In-Network Pharmacy you choose. The In-Network Pharmacy will automatically bill your Plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have your Member ID card with you when you fill your prescription, you or the pharmacy can call Express Scripts Medicare to get the necessary information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See **Chapter 5, Section 2** for information about how to ask the Plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility

If you're admitted to a hospital or to a skilled nursing facility, your Medicare Health Plan (Part A and B coverage) will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the Plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter. Please be aware that Medicare Part A and B only cover most prescription drugs if you are admitted to the facility. If you are being seen under "observation" status Medicare Part A and B may not cover the prescription drugs that are considered Self Administered Drugs (SAD). In this situation you will need to ask for reimbursement for the SAD drugs and they will be covered as Out-of-Network. See **Chapter 5, Section 2** for information about how to ask the Plan for reimbursement.

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Pharmacy Directory* or go to **HSMedicareRx.com** to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service at **(866) 264-4676**. If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in a long-term care (LTC) facility and need a drug that is not on our drug list or is restricted in some way, go to Section 5 for information about a temporary or emergency supply.

Section 9.3 What if you are taking drugs covered by Medicare Part A and B?

Your enrollment in HealthSelect Medicare Rx PDP doesn't affect your coverage for prescription drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you're enrolled in this Plan. If your drug would be covered by Medicare Part A or Part B, the Plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some prescription drugs may be covered under Medicare Part B in some situations and through HealthSelect Medicare Rx PDP in other situations. Prescription Drugs are never covered by both Part B and the Plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or HealthSelect Medicare Rx PDP for the drug.

Section 9.4 If you have a Medigap (Medicare Supplement Insurance) policy with drug coverage (other than through your former employer or retiree group)

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you enrolled in this Plan. If you decide to keep your current Medigap policy,

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your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your Premium. Medigap policies do not coordinate benefits with employer group plans. If you would like to be enrolled in the HealthSelect Medicare Rx PDP you must be enrolled in either the HealthSelect Medicare Advantage Plan or the HealthSelect Secondary Plan. If you have prescription drug coverage outside of the HealthSelect Medicare Rx plan it may automatically terminate your HealthSelect Medicare Advantage coverage.

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

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5	If you're also getting drug coverage from an employer or retiree group plan
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If you currently have other prescription drug coverage through your (or your spouse or common law spouse) employer or retiree group, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with your Plan.

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

Special note about creditable coverage

Each year your employer or retiree group should send you a notice that tells if your drug coverage for the next calendar year is creditable.

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

Section 9.6	If you're in Medicare-certified hospice
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Hospice and the Plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, the Plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before the Plan can cover the drug. To prevent delays in getting these drugs that should be covered by the Plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

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

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 like:

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

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

Section 10.1 Drug Management Program (DMP) to help Members safely use opioid medications
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We have a program that helps make sure Members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

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

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

Section 10.2	Medication Therapy Management (MTM) program to help Members manage their medications
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We have programs that can help our Members with complex health needs. One program is called a Medication Therapy Management (MTM) program. This program is voluntary and available to Members who qualify for the MTM program at no additional cost. A team of pharmacists and doctors developed the program for us to help make sure our Members get the most benefit from the drugs they take.

Some Members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through the MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, Members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other healthcare providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, please contact Customer Service at **(866) 264-4676**.

CHAPTER 4: What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice called *Important Information for Those Who Receive Extra Help Paying for Their 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 notice, please call Customer Service at **(866) 264-4676** and ask for the *LIS Rider*.

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. The Plan covers some drugs not normally covered by Medicare Part D.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your Covered Drugs. **Chapter 3** explains these rules. Examples of some of the materials where you can find more information about your specific Plan include the *Plan Guide*, the *Quick Reference Guide* and any notices you receive from us about changes to your coverage or conditions that affect your coverage.

When you use the Plan's **Price a Medication** tool to look up drug coverage, the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. The tool will indicate if the medication is not covered. You can also obtain information provided by the **Price a Medication** tool by calling Customer Service at **(866) 264-4676**.

Section 1.1 Types of Out-of-Pocket costs you may pay for Covered Drugs

There are different types of Out-of-Pocket costs for covered Part D drugs. The amount that you pay for a drug is called Cost Sharing, and there are two ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before the Plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your Out-of-Pocket costs

Medicare has rules about what counts and what doesn't count toward your Out-of-Pocket costs. Here are the rules we must follow to keep track of your Out-of-Pocket costs.

These payments are included in your Out-of-Pocket costs

Your Out-of-Pocket costs include the payments listed below (as long as they are for covered Part, and you followed the rules for drug coverage explained in **Chapter 3**):

- The amount you pay for drugs when you're in any of the following drug payment stages:
 - The Deductible stage
 - The Initial Coverage stage
- Any payments you made during this calendar year as a Member of a different Medicare prescription drug plan before you joined this 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* in your Out-of-Pocket costs 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, employer or union health plans, or by the Indian Health Service. Payments made by Medicare's Extra Help Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,400 in Out-of-Pocket costs within the calendar year, you will move to the Catastrophic Coverage Stage. **If you reach the Catastrophic Coverage stage, you pay nothing for covered Part D drugs.** The Plan covers additional drugs not normally covered by Medicare. You may have a cost share for such drugs covered under our enhanced benefit.

These payments aren't included in your Out-of-Pocket costs

Your Out-of-Pocket costs **don't include** any of these types of payments:

- The amount you or HealthSelect Medicare Rx PDP pays for your monthly Premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by the Plan
- Drugs you get at an Out-of-Network Pharmacy that don't meet the Plan's requirements for Out-of-Network coverage

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- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs that are made by group health plans, including employer health plans and TRICARE
- Payments for your drugs that are made by the Veterans Health Administration
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all of your Out-of-Pocket costs for drugs, you're required to tell the Plan by calling Customer Service at **(866) 264-4676**.

Tracking your Out-of-Pocket total costs

- The Part D *Explanation of Benefits (EOB)* summary we prepare for you includes the current amount of your Out-of-Pocket costs. When this amount reaches \$2,400, this summary will tell you that you have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to **Section 3.1** to learn what you can do to help make sure our records of what you have spent are complete and up to date.

SECTION 2 Drug payment stages for HealthSelect Medicare Rx PDP members

As shown in the table on the next page, there are three drug payment stages for the HealthSelect Medicare Rx PDP Plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled.

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STAGE 1 <i>Yearly Deductible stage</i>	STAGE 2 <i>Initial Coverage stage</i>	STAGE 3 <i>Catastrophic Coverage stage</i>
You begin in this stage when you fill your first prescription of the plan year. During this stage, you pay the full cost of your drugs. You stay in this stage until you have paid the \$50 deductible listed in your <i>Plan Guide</i>. Note: This deductible does not apply to <i>Formulary</i> insulin products filled at an In-Network Pharmacy. (Details are in Section 4 of this chapter.)	During this stage, the Plan pays its share of the cost of your drugs and you pay your share of the cost. Your share is shown in your <i>Plan Guide</i>. You stay in this stage until your year-to-date total drug costs (your payments plus any Part D plan's payments) total \$2,400. (Details are in Section 5 of this chapter.)	During this stage, the Plan pays the full cost for your covered Part D drugs for the rest of the plan year (through December 31, 2027). (Details are in Section 6 of this chapter.) Your Plan covers additional drugs not normally covered by Medicare. You may have a cost share for such drugs covered under an enhanced benefit.

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

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

The Plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. We track two types of costs:

- **Out-of-Pocket costs:** this is how much you have paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug costs.** This is the total of all payments made for your covered Part D drugs. It includes what the Plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

The Plan will prepare a written summary called the Part D *Explanation of Benefits* (Part D *EOB*) when you have had one or more prescriptions filled through the Plan during the previous month. The Part D *EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what the Plan paid, and what you and others paid on your behalf paid.

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- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower Cost Sharing for each prescription claim, if applicable.

Section 3.1**Help us keep your information about your drug payments up to date**

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

- **Show your HealthSelect Medicare Rx PDP ID card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your Out-of-Pocket costs. To help us keep track of your Out-of-Pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at an In-Network Pharmacy at a special price or use a discount card that's not part of the Plan's benefit.
 - When you pay a Copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy Prescription drugs at Out-of-Network pharmacies or pay the full price for a covered drug under special circumstances.
 - If you're billed for a covered drug, you can ask the Plan to pay our share of the cost. For instructions on how to do this, go to **Chapter 5, Section 2.**
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your Out-of-Pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your Out-of-Pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the *Explanation of Benefits (Part D EOB)* we send you.** When you use your Part D prescription drug benefits, **HealthSelect Medicare Rx PDP** sends you an EOB, or summary, to help you understand and keep track of your benefits. This is sent to you the month after you've filled a prescription. You may also be able to receive a copy electronically by visiting our website, **HSMedicareRx.com**, or by contacting Customer Service at **(866) 264-4676**.

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SECTION 4 The Deductible Stage

The Deductible stage is the first payment stage for your drug coverage. This stage begins at the beginning of each year when you fill your first prescription. When you're in this payment stage, **you must pay the full cost of your drugs that apply to your deductible** until you reach the Plan's deductible amount. The deductible doesn't apply to *Formulary* insulin products filled at an In-Network Pharmacy, and most Part D vaccines, including shingles, tetanus and travel vaccines.

Important Message About What You Pay For Insulin: The annual prescription deductible does not apply to insulin. You will be responsible for up to a \$25 Copayment for each 30-day supply of insulin, no matter what Cost-Sharing Tier it is on, even if you haven't paid your Part D deductible. You won't pay more than \$25 for a one-month supply, more than \$50 for up to a two-month supply, or more than \$75 for up to a three-month supply of each covered insulin product regardless of the Cost-Sharing tier.

Your Plan has a deductible of \$50. However, your deductible will be different if you receive Medicare's Extra Help with your prescription drug costs. Depending on the level of Extra Help you receive, your deductible may be as low as \$0. This will only apply to Part D drugs. The \$50 deductible will still apply to drugs covered under our enhanced benefit.

Once you pay the deductible amount, you leave the Deductible stage and move on to the Initial Coverage stage.

SECTION 5 The Initial Coverage Stage

Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage stage, the Plan pays its share of the cost of your covered prescription drugs, and you pay your share (your Copayment amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The Plan has 3 Cost-Sharing Tiers

Every drug on the Plan's drug list is in one of 3 Cost-Sharing Tiers. In general, the higher the Cost-Sharing tier number, the higher your cost for the drug:

Tier 1 – Preferred Generic: All covered generic drugs. This is the lowest Cost-Sharing Tier.

Tier 2 – Preferred Brand: Many common brand name drugs, called preferred brands.

Tier 3 – Non-Preferred Drug: Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.

To find out which Cost-Sharing Tier your drug is in, you can look it up in the Plan's drug list, use the **Price a Medication** tool at **HSMedicareRx.com** or call Customer Service at **(866) 264-4676**.

Your pharmacy choices

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

- A network retail pharmacy
- A network retail pharmacy that is in the Plan's Extended Day Supply (EDS) network
- A pharmacy that isn't in the Plan's network. We cover prescriptions filled at Out-of-Network pharmacies in only limited situations. Go to **Chapter 3, Section 2.4** to find out when we'll cover a prescription filled at an Out-of-Network Pharmacy.
- The Plan's home delivery pharmacy, Express Scripts Pharmacy.
- Note: You will never pay more than \$25 for up to a 30-day supply of insulin, regardless of where you get the insulin.

For more information about these pharmacy choices and filling your prescriptions, go to **Chapter 3** and the Plan's *Pharmacy Directory* (visit **HSMedicareRx.com**).

Section 5.2	Your costs for covered Part D drugs
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During the Initial Coverage stage, your share of the cost of a covered drug will be a Copayment.

- **Copayment** means that you pay a fixed amount each time you fill a prescription.

As shown in the table on the next page, the amount of the Copayment depends on which Cost-Sharing Tier the drug is in.

- If your covered drug costs less than the Copayment amount, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the Copayment amount, *whichever is lower*.
- We cover prescriptions filled at Out-of-Network pharmacies only in limited situations. Please see **Chapter 3, Section 2.4** for information about when we will cover a prescription filled at an Out-of-Network Pharmacy.
- You won't pay more than \$25 for a one-month supply, more than \$50 for up to a two-month supply, or more than \$75 for up to a three-month supply of each covered insulin product regardless of the Cost-Sharing tier, even if you haven't paid your deductible.

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Your share of the cost when you get a covered Part D prescription drug from an In-Network retail pharmacy:

Tier	Retail Cost-Sharing		Retail Cost Share in the Extended Days' Supply (EDS) Network	
	(30-day supply of non-maintenance drugs)	(30-day supply of maintenance drugs*)	(31 to 60-day supply)	(61- to 90-day supply)
Cost-Sharing Tier 1 Preferred Generic	\$10 Copayment	\$10 Copayment	\$20 Copayment	\$30 Copayment
Cost-Sharing Tier 2 Preferred Brand	\$35 Copayment	\$45 Copayment	\$70 Copayment	\$105 Copayment
Cost-Sharing Tier 3 Non-preferred Drug	\$60 Copayment	\$75 Copayment	\$120 Copayment	\$180 Copayment

*Maintenance medications are medications used to treat chronic conditions such as high blood pressure, diabetes and arthritis. These medications might be needed for months, years, or even a lifetime. They are often prescribed with refills and available in 60- to 90-day supplies. Tier 2 and Tier 3 Maintenance medications filled for less than a 60-day supply have a higher copayment.

The table below shows what you pay when you get more than a one-month supply of drugs from the Plan's mail order pharmacy.

Your share of the cost when you get a covered Part D prescription drug through our mail-order service (also called home delivery):

Tier	Mail Order Cost-Sharing	
	(35- to 60-day supply)	(61- to 90-day supply)
Cost-Sharing Tier 1 Preferred Generic	\$20 Copayment	\$30 Copayment
Cost-Sharing Tier 2 Preferred Brand	\$70 Copayment	\$105 Copayment
Cost-Sharing Tier 3 Non-preferred Drug	\$120 Copayment	\$180 Copayment

Go to **Section 8** of this chapter for more information on Cost Sharing for Part D vaccines.

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

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

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

- If you're responsible for a Copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the Daily Cost-Sharing Rate) and multiply it by the number of days of the drug you get.

Section 5.4 You stay in the Initial Coverage Stage until your Out-of-Pocket costs for the year reach \$2,400

You stay in the Initial Coverage stage until your total Out-of-Pocket costs reach \$2,400. You then move to the Catastrophic Coverage stage.

The Part D *EOB* we prepare for you will help you keep track of how much you, the Plan, and any third parties have spent on your behalf during the year. Not all Members will reach the \$2,400 Out-of-Pocket limit in a year.

We'll let you know if you reach this amount. Go to **Section 1.2** for more information on how Medicare calculates your Out-of-Pocket costs.

SECTION 6 The Catastrophic Coverage Stage

You enter the Catastrophic Coverage stage when your Out-of-Pocket costs have reached the \$2,400 limit for the calendar year. Once you are in the Catastrophic Coverage stage, you will stay in this payment stage until the end of the calendar year.

If you reach the Catastrophic Coverage stage, you pay nothing for covered Part D drugs. The Plan covers additional drugs not normally covered by Medicare. You may have a cost share for such drugs covered under the enhanced benefit. You will pay no more than the cost shares you paid in the Initial Coverage stage for drugs covered under our enhanced benefit and you may pay less for certain drugs.

SECTION 7 Additional benefits information

This part of **Chapter 4** talks about limitations of the Plan.

1. The Plan covers early refills for lost, stolen, or destroyed drugs (excluding narcotics).
2. Early refills for vacation supplies are limited to a one-time fill once every 180 days.

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3. Medications won't be covered if prescribed by physicians or other providers who are excluded or precluded from participating in the Medicare program.
4. You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days' supply.
5. Costs for drugs that are not covered under Part D do not count toward your Out-of-Pocket costs.

SECTION 8 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are covered under Medicare Part D. The Plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. You can find these vaccines listed in the Plan's drug list. **Because coverage for vaccines can be complicated, we suggest that you call Customer Service at (866) 264-4676 prior to receiving any vaccinations if you have any concerns.**

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (These are sometimes called administration fees.)

Your costs for Part D vaccines depend on three things:

- 1. The type of vaccine** (what you are being vaccinated for)
 - Some vaccines are considered Part D drugs.
 - Part D plans cover all commercially available vaccines when they're reasonable and necessary to prevent illness, except those covered by Part B
 - Other vaccines are considered medical benefits. They are covered under Medicare Part B.
 - Part B covers vaccines and vaccine administration for:
 - Flu
 - Pneumonia
 - Hepatitis B (for people at high and intermediate risk)
 - COVID-19
 - Certain reasonable and necessary vaccines to treat an injury or exposure to a disease
- 2. Where you get the vaccine**
 - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
- 3. Who gives you the vaccine**
 - A pharmacist or another provider may give the vaccine in the pharmacy. Or, a provider may give it in the doctor's office.

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

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask the Plan to pay you back for our share of the cost. For most Part D vaccines, this means you'll be reimbursed the entire cost you paid.

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- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most Part D vaccines, you pay nothing.

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

Situation 1: You get the Part D vaccine at the In-Network Pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.) The In-Network Pharmacy will bill the Plan and

- For most Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your Copayment for the vaccine itself, which includes the cost of giving you the vaccine.

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

- When you get the vaccine at a doctor's office the doctor is considered an Out-of-Network Pharmacy. You will pay the entire cost of the vaccine itself and any administration fees.
- You can then ask the Plan to reimburse you for the cost by using the procedures described in **Chapter 5**.
- For most Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any normal 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'll reimburse you for this difference.)

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

- The In-Network Pharmacy will bill the Plan
- For most Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your Copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay for the administration fee. You can then ask the Plan to pay our share of the cost by using the procedures described in **Chapter 5**.
- For most Part D vaccines, you'll be reimbursed the full amount you paid the doctor. For other Part D vaccines, you'll be reimbursed the amount you paid less any Copayment or the vaccine administration.

CHAPTER 5:

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

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

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

Examples of situations in which you may need to ask the Plan to pay you back or to pay a bill you received.

1. When you use an Out-of-Network Pharmacy to fill a prescription

If you go to an Out-of-Network Pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription. **Remember that we only cover Out-of-Network pharmacies in limited circumstances.**

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Go to **Chapter 3, Section 2.4** to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the Out-of-Network Pharmacy and the amount we'd pay at an In-Network pharmacy.

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

If you don't have your Plan Member ID card with you, you can ask the pharmacy to call the Plan or look up your enrollment information. However, if the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the difference between what you paid for the drug at the Out-of-Network Pharmacy and the amount that we would pay at an In-Network Pharmacy.

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

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on the Plan's drug list, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the difference between what you paid for the drug at the Out-of-Network Pharmacy and the amount that we would pay at an In-Network pharmacy.

4. If you're retroactively enrolled in the Plan

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

If you were retroactively enrolled in the Plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You'll need to submit paperwork for us to handle the reimbursement. You must submit your claim to us within 36 months of the date you received the service, item or drug.

5. In a medical emergency

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

6. When traveling

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. You may be able to obtain your prescription drugs ahead of time. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we'll cover prescriptions that are filled at an Out-of-Network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an Out-of-Network pharmacy, call Customer Service at **(866) 264-4676** to find out if there is an In-Network pharmacy in the area where you're traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an Out-of-Network pharmacy. We cannot pay for any prescriptions that are filled outside the United States, even for a medical emergency.

7. To obtain a covered drug in a timely manner

In some cases, you may be unable to get a covered drug in a timely manner within our Service Area. If there is no In-Network Pharmacy within a reasonable driving distance that provides 24-hour service, we'll cover your prescription at an Out-of-Network Pharmacy. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

8. If an In-Network Pharmacy does not stock a covered drug

Some prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible network retail pharmacy or through our home delivery pharmacy. We will cover prescriptions at an Out-of-Network Pharmacy under these circumstances. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

SECTION 2 How to ask us to pay you back

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 36 months** of the date you received the service, item or drug.

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website, **HSMedicareRx.com** or call Customer Service and ask for a Direct Claim Form.

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

Express Scripts
Attn: Medicare Part D
P.O. Box 52023
Phoenix, AZ 85072

You also have the option of faxing your claim form and receipts to **(608) 741-5483**.

To submit online: visit **HSMedicareRx.com**, log in and select **Benefits > Forms & Cards**.

Be sure to contact Customer Service at **(866) 264-4676** if you have any questions. 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'll consider your request for payment and say yes or no

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

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

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Section 3.1	If we tell you that we won't pay for all or part of the drug, you can make an Appeal
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If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an Appeal. If you make an Appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The Appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this Appeal, go to **Chapter 7** of this document.

CHAPTER 6: Your rights and responsibilities

SECTION 1 We must honor your rights and cultural sensitivities as a Member of this Plan

Section 1.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)
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Your Plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how your Plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Your Plan has free interpreter services available to answer questions from non-English speaking Members. We also offer Plan materials in Spanish. We can give you materials in braille, large print, or other alternate formats at no cost if you need it. We're required to give you information about your 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, call Customer Service at **(866) 264-4676**.

If you have any trouble getting information from the Plan in a format that's accessible and appropriate for you, call to file a Grievance with the Plan (see **Chapter 2, Section 1** for contact information). You can also file a Complaint with Medicare by calling (800) MEDICARE (800) 633-4227 or directly with the Office for Civil Rights at (800) 368-1019 or TTY (800) 537-7697.

Sección 1.2	Debemos proporcionar información de una manera que funcione para usted y sea compatible con sus sensibilidades culturales (en otros idiomas además de inglés, braille, letra grande o en otros formatos alternativos, etc.)
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Su Plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y sean accesibles para todos los afiliados, incluidas las personas que tienen una competencia limitada en inglés, habilidades de lectura limitadas o una discapacidad auditiva, o personas con orígenes culturales y étnicos diversos. Algunos ejemplos de cómo un Plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traductores, servicios de intérpretes, teletipos o conexión de TTY (teléfono de texto o teléfono de teletipo).

Nuestro Plan cuenta con servicios gratuitos de intérpretes disponibles para responder preguntas de miembros que no hablan inglés. También ofrecemos los materiales del Plan en español. Si lo necesita, podemos brindarle información en braille, letra grande u otros formatos alternativos sin costo alguno. Debemos brindarle información sobre los beneficios del Plan en un formato que sea adecuado

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para usted y al que pueda acceder. Para obtener información de parte nuestra de una manera que funcione para usted, llame a Servicio al Cliente al **(866) 264-4676**.

Si tiene problemas para obtener información de nuestro Plan en un formato que sea accesible y adecuado para usted, llame para presentar una queja formal ante nuestro Plan (consulte la **Sección 1 del Capítulo 2** para obtener la información de contacto). También puede presentar una queja ante Medicare si llama al (800) MEDICARE (800) 633-4227) o directamente a la Oficina de Derechos Civiles al (800) 368-1019 o TTY: (800) 537-7697.

Section 1.3	We must ensure you get timely access to your Covered Drugs
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You have the right to get your prescriptions filled or refilled at any of our In-Network pharmacies without long delays. If you think that you aren't getting your Part D drugs within a reasonable amount of time, **Chapter 7** tells what you can do.

Section 1.4	We must protect the privacy of your personal health information
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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.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practices*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain Exceptions that don't require us to get your written permission first. These Exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a Member of the Plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

Chapter 6**You can see the information in your records and know how it's been shared with others**

You have the right to look at your medical records held at the Plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, call Customer Service at **(866) 264-4676**.

Section 1.5 We must give you information about the Plan, our network of pharmacies, and your Covered Drugs

As a Member of HealthSelect Medicare Rx PDP, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service at **(866) 264-4676**.

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

Section 1.6 You have the right to know your treatment options and participate in decisions about your care**You have the right to give instructions about what's to be done if you can't make medical decisions for yourself**

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, 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 out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions are not followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a Complaint with the appropriate state-specific agency (such as the State Department of Health).

Section 1.7	You have the right to make Complaints and ask us to reconsider decisions we made
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If you have any problems, concerns, or Complaints and need to ask for coverage, or make an Appeal, **Chapter 7** of this document tells what you can do. Whatever you do—ask for a coverage decision, make an Appeal, or make a Complaint—we're required to treat you fairly.

Section 1.8	If you believe you're being treated unfairly, or your rights aren't being respected
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If you believe you have been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at (800) 368-1019 TTY users call: (800) 537-7697, or call your local Office for Civil Rights.

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

- **Call Customer Service** at (866) 264-4676.
- **Call your local SHIP.** For details, go to **Chapter 2, Section 3**; for information on how to contact the SHIP in your state, go to the **Appendix**.
- **Call Medicare** at (800) MEDICARE (800) 633-4227 (TTY users call (877) 486-2048).

Section 1.9 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service** at (866) 264-4676.
- **Call your local SHIP.** For details, go to **Chapter 2, Section 3**.
- **Contact Medicare.**
 - Visit the Medicare website to read or download the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections)
 - Or, you can call (800) MEDICARE (800) 633-4227, 24 hours a day, seven days a week (TTY: (877) 486-2048).

SECTION 2 Your responsibilities as a Member of the Plan

Things you need to do as a Member of the Plan are listed below. For questions, call Customer Service at (866) 264-4676.

- **Get familiar with your Covered Drugs and the rules you must follow to get these Covered Drugs.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get your Covered Drugs.
 - **Chapters 3 and 4** give details about Part D drug coverage.
- **If you have any other drug coverage in addition to this Plan, you're required to tell us.** **Chapter 1** tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you're enrolled in this Plan.** Show your HealthSelect Medicare Rx PDP ID card whenever you get Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.

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- **Pay what you owe.** As a Plan Member, you're responsible for these payments:
 - Your drug coverage is provided through a contract with ERS. Please contact ERS for information about your Plan Premium, if applicable. If you have a Plan Premium, you must pay your Plan Premiums to continue being a Member of this Plan.
 - For most of your drugs covered by the Plan, you must pay your share of the cost when you get the drug.
 - If you're enrolled in the Medicare Prescription Payment Plan, you must make monthly payments.
 - If you're required to pay a late enrollment penalty, you must pay the penalty to stay a Member of the Plan. Please note: ERS pays this penalty once you are enrolled in the HealthSelect Medicare Rx PDP.
 - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a Member of the Plan.
- **If you move *within* the Plan Service Area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of the Plan Service Area, you can't stay a Member of the Plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7: What to do if you have a problem or concern (Coverage Decisions, Appeals, Complaints)

SECTION 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 problems, you need to use the **process for coverage decisions and Appeals**.
- For other problems, you need to use the **process for making Complaints**, also called Grievances.

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

- 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's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized assistance

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at **(866) 264-4676** for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call (800) MEDICARE ((800) 633-4227), 24 hours a day, seven days a week. TTY users should call (877) 486-2048.
- Visit [Medicare.gov](https://www.Medicare.gov)

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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.

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

Yes.

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

No.

Go to **Section 7, How to make a Complaint about quality of care, waiting times, Customer Service at (866) 264-4676, or other concerns**.

Coverage decisions and Appeals

SECTION 4 A guide to coverage decisions and Appeals

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

Asking for coverage decisions before you get benefits

If you want to know if we'll cover a specific prescription drug before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your prescription drugs.

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

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

Making an Appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can Appeal the decision. An Appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or *fast Appeal* of a coverage decision. Your Appeal is handled by different reviewers than those who made the original decision.

When you Appeal a decision for the first time, this is called a Level 1 Appeal. In this Appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

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

If we do not dismiss your case but say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent review organization that is not connected to us.

If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of Appeal (This chapter explains Level 3, 4, and 5 Appeals).

Chapter 7**Section 4.1 Get help asking for a coverage decision or making an appeal**

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

- **Call Customer Service at (866) 264-4676.**
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 Appeal on your behalf. If your Level 1 Appeal is denied, your doctor or prescriber can ask for a Level 2 Appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an Appeal.
 - If you want a friend, relative, or another person to be your representative, call Customer Service at **(866) 264-4676** and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person who you'd like to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or Appeal a decision.

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

Section 5.1 What to do if you have problems getting a Part D drug or want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a Medically Accepted Indication. (Go to **Chapter 3** for more information about a Medically Accepted Indication.) For details about Part D drugs, rules, restrictions, and costs go to **Chapters 3 and 4**. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term drug list or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we'll cover it.

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- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and Appeals

Legal Term
An initial coverage decision about your Part D drugs is called a Coverage Determination .

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

- Asking to cover a Part D drug that's not on the Plan's drug list. **Ask for an Exception. Section 5.2**
- Asking to waive a restriction on the Plan's coverage for a drug (such as limits on the amount of the drug you can get, Prior Authorization criteria, or the requirement to try another drug first. **Ask for an Exception. Section 5.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher Cost-Sharing Tier. **Ask for an Exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

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

This section tells you both how to ask for coverage decisions and how to request an Appeal.

Section 5.2	Asking for an Exception
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Legal Terms
Asking for coverage of a drug that is not on the drug list is sometimes called asking for a Formulary Exception .
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a Formulary Exception .
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a tiering Exception .

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **Exception**. An Exception is a type of coverage decision.

For us to consider your Exception request, your doctor or another prescriber will need to explain the medical reasons why you need the Exception approved. Below are three examples of Exceptions that you or your

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doctor or other prescriber can ask us to make. (Please note that not all of these examples apply to all

HealthSelect Medicare Rx PDP Plans. To find out if this applies to your HealthSelect Medicare Rx PDP Plan, visit us online at **HSMedicareRx.com** and click on **Resources** to view a PDF of your Plan's *Formulary*. You may also call Customer Service at **(866) 264-4676**.

1. **Covering a drug for you that's not on our drug list.** If we agree to cover a drug not on the drug list, you'll need to pay the cost-sharing amount that is set by the Plan. You can't ask for an Exception to the Cost-Sharing amount we require you to pay for the drug when we agree to cover a drug not on the drug list.
2. **Removing a restriction for a Covered Drug.** Chapter 3 describes the extra rules or restrictions that apply to certain drugs we cover. If we agree to make an Exception and waive a restriction for you, you can ask for an Exception to the copayment amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower Cost-sharing tier.** Every drug on our drug list is in a specific Cost-Sharing Tier. You can see what tier a drug is in by checking your plan's *Formulary (drug list)* online at **HSMedicareRx.com** and click on **Resources** to view a PDF of your Plan's *Formulary*. You may also call Customer Service at **(866) 264-4676**. In general, the lower the Cost-Sharing Tier number, the less you pay as your share of the cost of the drug.
 - If our drug list contains alternative drug(s) for treating your medical condition that is in a lower Cost-Sharing Tier than your drug, you can ask us to cover your drug at the Cost-Sharing amount that applies to the alternative drug(s).
 - If the drug you're taking is a Biological Product, you can ask us to cover your drug at a lower Cost-Sharing amount. This would be the lowest tier cost that contains Biological Product alternatives for treating your condition.
 - If the drug you're taking is a 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.
 - We do not lower the Cost-Sharing level for high-cost specialty drugs.
 - If we approve your tiering Exception request and there's more than one lower Cost-Sharing Tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 5.3	Important things to know about asking for Exceptions
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Your doctor must tell us the medical reasons

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

The drug list typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative drugs**. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an Exception. If you ask us for a tiering Exception, we generally won't approve your request for an Exception unless all the alternative drugs in the lower Cost-Sharing Tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

Chapter 7**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, you can ask for another review by making an Appeal.
- You may have to request an Exception at the beginning of each plan year.

Section 5.4	How to ask for a coverage decision, including an exception
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Legal Term

A fast coverage decision is called an expedited Coverage Determination .

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

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

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

- You must be asking for a drug you didn't get. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Tells you how you can file a fast Complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your Complaint within 24 hours of receipt of the Complaint.

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

Start by calling, writing, or faxing the Plan to ask us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website at **HSMedicareRx.com**. **Chapter 2** has contact information. To help us

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process your request, include your name, contact information, and information that show which denied claim is being Appealed.

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

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

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we get your request.
 - For Exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. we'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request on to Level 2 of the Appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to provide within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can Appeal.

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

- We must generally give you our answer **within 72 hours** after we get your request.
 - For Exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the Appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to provide **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can Appeal.

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

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

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

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

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

Section 5.5 How to make a Level 1 Appeal**Legal Terms**

An Appeal to the Plan about a Part D drug coverage decision is called a Plan **redetermination**.

A fast Appeal is called an **expedited redetermination**.

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

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

- If you're appealing a decision we made about a drug, you and your doctor or other prescriber will need to decide if you need a fast Appeal.
- The requirements for getting a fast Appeal are the same as those for getting a fast coverage decision in **Section 5.4** of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **fast Appeal**.

- **For standard Appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast Appeals, either submit your Appeal in writing or call us at the phone numbers shown in Chapter 2.**
- **We must accept any written request**, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available at **HSMedicareRx.com**. Please be sure to include your name, contact information, and information about your claim to help us in process your request.
- **You must make your Appeal request within 65 calendar days** from the date on the written notice

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we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your Appeal is late when you make your Appeal.

We may give you more time to make your Appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an Appeal.

- **You can ask for a copy of the information in your Appeal and add more information.** You and your doctor may add more information to support your Appeal.

Step 3: We consider your Appeal and give you our answer.

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

Deadlines for a fast Appeal

- For fast Appeals, we must give you our answer **within 72 hours after we get your Appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the Appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. **Section 5.6** explains the Level 2 Appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your Appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can Appeal our decision.

Deadlines for a standard Appeal for a drug you didn't get yet

- For standard Appeals, we must give you our answer **within 7 calendar days** after we get your Appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within 7 calendar days, we are required to send your request to Level 2 of the Appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. **Section 5.6** explains the Level 2 Appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your Appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can Appeal our decision.

Deadlines for a standard Appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we are required to send your request on to Level 2 of the Appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review

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organization.

- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within **30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no. We'll also tell you how you can Appeal.

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

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

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

Legal Term

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the independent review organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information we have about your Appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your Appeal.

Step 2: The independent review organization reviews your Appeal.

- Reviewers at the independent review organization will take a careful look at all the information

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related to your Appeal.

Deadlines for fast Appeal

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

Deadlines for standard Appeal

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

Step 3: The independent review organization gives you its answer.***For fast Appeals:***

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

For standard Appeals:

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

What if the independent review organization says no to your Appeal?

If this organization says no to part or all of your Appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your Appeal**.) In this case, the independent review organization will send you a letter that:

- Explains its decision.
- Let's you know about your right to a Level 3 Appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another Appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the Appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your Appeal further.

- There are three additional levels in the Appeals process after Level 2 (for a total of five levels of Appeal).
- If you want to go to a Level 3 Appeal, the details on how to do this are in the written notice you get after your Level 2 Appeal decision.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 6** explains more about Levels 3, 4, and 5 of the Appeals process.

SECTION 6 Taking your Appeal to Levels 3, 4 and 5

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

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

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

For most situations that involve Appeals, the last three levels of Appeal work in much the same way as the first two levels. Here's who handles the review of your Appeal at each of these levels.

Level 3 Appeal

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

- **If the answer is yes, the Appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited Appeals)** or make payment no later than 30 calendar days after we get the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your Appeal, the Appeals process *may* or *may not* be over.**
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) will review your Appeal and give you an answer. The

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Council is part of the federal government.

- **If the answer is yes, the Appeals process *is* over.** We must authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited Appeals) or make payment no later than 30 calendar days after we get the decision. If the answer is no or if the Council denies the review request, the Appeal process may or may not be over.
- **If the answer is no or if the Council denies the review request, the Appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your Appeal, the Appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your Appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 Appeal and how to continue with a Level 5 Appeal.

Level 5 Appeal

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

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

Chapter 7**Making complaints****SECTION 7 How to make a Complaint about quality of care, waiting times, Customer Service, or other concerns****Section 7.1 What kinds of problems are handled by the Complaint process?**

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

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our customer service? • Do you feel you're being encouraged to leave the Plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at the Plan? ◦ Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and Appeals)	If you asked for a coverage decision or made an Appeal, and you think that we aren't responding quickly enough, you can make a Complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast Appeal, and we have said no; you can make a Complaint. • You believe we aren't meeting the deadlines for coverage decisions or Appeals; you can make a Complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a Complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a Complaint.

Section 7.2 How to make a Complaint

Legal Terms

- A **Complaint** is also called a **Grievance**.
- **Making a Complaint** is also called **filing a Grievance**.
- **Using the process for Complaints** is also called **using the process for filing a Grievance**.
- A **fast Complaint** is also called an **expedited Grievance**.

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

- **Calling Customer Service at (866) 264-4676 (TTY: (800) 716-3231) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your Complaint in writing and send it to us.** If you put your Complaint in writing, we'll respond to your Complaint in writing.
- The **deadline** for making a Complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

- **If possible, we'll answer you right away.** If you call us with a Complaint, we may be able to give you an answer on the same phone call.
- **Most Complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your Complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a Complaint because we denied your request for a fast coverage decision or a fast Appeal, we'll automatically give you a fast Complaint.** If you have a fast Complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your Complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

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

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

- **You can make your Complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other healthcare experts paid by the federal government to check and improve the care given to Medicare patients. **Chapter 2** has contact information.

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Or

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

Section 7.4	You can also tell Medicare about your Complaint
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You can submit a Complaint about HealthSelect Medicare Rx PDP directly to Medicare. To submit a Complaint to Medicare, go to [Medicare.gov/MedicareComplaintForm/home.aspx](https://www.Medicare.gov/MedicareComplaintForm/home.aspx). You may also call (800) MEDICARE (800) 633-4227. TTY users can call (877) 486-2048.

CHAPTER 8:

Ending membership in the Plan

SECTION 1 Ending your membership in the Plan

Ending your membership in HealthSelect Medicare Rx PDP may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave this Plan because you decide you want to end your membership. **Section 2** provides information on ending your membership voluntarily. **You should always check with ERS before leaving this Plan.**
- There are also limited situations where we're required to end your membership. **Section 5** tells you about situations when we must end your membership.

If you're leaving this Plan, we must continue to provide your prescription drugs, and you'll continue to pay your cost share until your membership ends.

In the event you choose to end your membership in the Plan, re-enrollment may not be permitted, or you may have to wait until ERS' next Fall Enrollment period.

You may request to end your membership in the HealthSelect Medicare Rx PDP Plan at any time. To request to leave, call ERS at **(877) 275-4377 (TTY: 711)** from 8 a.m. – 5 p.m. CT, Monday – Friday. Please note that you will not have any prescription drug coverage through ERS if you end your membership in the HealthSelect Medicare Rx PDP Plan. If you decide to re-enroll in the HealthSelect Medicare Rx PDP Plan at a later date contact ERS. If you decide to enroll later, your coverage will not become effective right away.

SECTION 2 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership, you can:

- Call ERS toll-free at **(877) 275-4377 (TTY: 711)** from 8 a.m. – 5 p.m. CT, Monday – Friday.
- Call **Customer Service** at **(866) 264-4676**.
- Find the information in the *Medicare & You 2027* handbook.
- Contact **Medicare** at (800) MEDICARE (800) 633-4227, 24 hours a day, seven days a week. (TTY: (877) 486-2048).

SECTION 3 Until your membership ends, you must keep getting your drugs through this Plan to receive coverage

Until your membership ends, and your new Medicare coverage starts, you must continue to use our In-Network pharmacies in order to receive benefits for prescription drugs under this Plan.

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The Plan will continue to offer coverage until your membership ends as long as you continue to follow Plan rules. After your coverage end date in this Plan, you will need to provide the pharmacy with your new plan information.

SECTION 4 Express Scripts Medicare must end your membership in the Plan in certain situations

Section 4.1 When must we end your membership in the Plan?

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

- We are notified you no longer meet the eligibility requirements of ERS (Plan sponsor).
- ERS' contract with us is terminated.
- If you no longer have either Medicare Part A or Part B.
- If you move out of the Service Area.
- If you're away from our Service Area for more than 12 months.
 - If you move or take a long trip, call Customer Service at **(866) 264-4676** to find out if the place you're moving or traveling to is in the Plan's Service Area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or national, or an eligible noncitizen.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in the Plan and that information affects your eligibility for the Plan. (We can't make you leave the 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 the Plan. (We can't make you leave the Plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your Member ID card to get prescription drugs. (We can't make you leave the Plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from the Plan and you will lose drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Service at **(866) 264-4676**.

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Section 4.2 We can't ask you to leave the Plan for any health-related reason

HealthSelect Medicare Rx PDP isn't allowed to ask you to leave the Plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave the Plan because of a health-related reason, call Medicare at (800) MEDICARE (800) 633-4227), TTY users call: (877) 486-2048.

Section 4.3 You have the right to make a Complaint if we end your membership in the Plan

If we end your membership in this Plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a Grievance or can make a Complaint about our decision to end your membership.

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, 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 this Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at (800) 368-1019 (TTY: (800) 537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at [HHS.gov/ocr/index.html](https://www.hhs.gov/ocr/index.html).

If you have a disability and need help with access to care, please call us at **(866) 264-4676**. If you have a Complaint, such as a problem with wheelchair access, Customer Service 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, Express Scripts Medicare, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Third party liability and subrogation

For purposes of this Section Four only, when this Section Four says "we," "us," or "our," it means Express Scripts Medicare for itself and, as the pharmacy benefit manager for HealthSelect Medicare Rx PDP, on behalf of HealthSelect Medicare Rx PDP and ERS.

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In the case of injuries or illness caused by or alleged to have been caused by any act or omission of a third party, and any complications incident thereto, we shall cover all Part D prescription drugs.

However, you agree to promptly notify Express Scripts Medicare of the injury or illness and agree to reimburse us or our designee for the cost of all such drugs provided immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of Express Scripts Medicare or its designee under this provision.

You shall not settle any claim, or release any person from liability, without the written consent of Express Scripts Medicare, wherein such release or settlement will extinguish or act as a bar to our right of reimbursement. Should you settle your claim against a third party and compromise the reimbursement rights of Express Scripts Medicare or its nominee without our written consent, or otherwise fail to cooperate in protecting the reimbursement rights of Express Scripts Medicare or its nominee, we may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

Benefits paid by us may also be considered to be benefits advanced.

This Plan has a right to subrogation and reimbursement. Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree to assign us all rights of recovery against such Third Parties; to the extent of the reasonable value of services and benefits we provide to you, plus reasonable costs of collection. We or any of our subsidiaries or owned affiliates are not a Third Party under this Plan.

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The following is agreed upon between you and us:

- You will cooperate with us in protecting our legal rights to subrogation and reimbursement; and you acknowledge that our rights under this Section will be considered as the first priority claim against any Third Parties, to be paid before any of your other claims are paid. Specifically, but without limitation you agree to: (i) provide any relevant information we may request; (ii) sign and deliver such documents as we or our agents may reasonably request to secure the subrogation claim; (iii) respond to requests for information about any accidents or injuries; (iv) make court appearances; (v) obtain the consent of the Plan or our agents before releasing any party from liability for or payment of medical expenses. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf; and (vi) you may not accept any settlement that does not fully reimburse us without its written approval.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- You will do nothing to prejudice our rights under this provision, either before or after the need for drugs under this *Evidence of Coverage*. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit on our own behalf as your subrogee. Your failure to cooperate in this manner shall be deemed a breach of this contract and may result in the institution of legal action against you.
- We will not use the rights enumerated throughout this Section to affect or impair any parental financial obligations, such as child support, associated with Pregnancy.
- No court costs or attorney's fees may be deducted from our recovery without our express written consent; and no so-called Fund Doctrine or Common Fund Doctrine or Attorney's Fund Doctrine shall defeat this right. We are not required to participate in or pay court costs or attorney's fees to any attorney or other representative or agent hired by you to pursue a claim relating to your Sickness or Injury.
- We may collect, at our opinion, amounts from proceeds of any Third Party settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether you or your legal representative have been made whole. You will hold any proceeds of such a third-party settlement or judgment in a constructive trust for our benefit under these subrogation provisions. We will be entitled to recover from you reasonable attorney fees incurred in collecting proceeds held by you.
- This Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

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- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- We have the responsibility for administering the terms and conditions of the subrogation and reimbursement rights and have such powers and duties as are necessary to discharge these duties and functions, including the exercise of discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

SECTION 5 Member liability

In the event we fail to reimburse In-Network charges for Prescription drugs, or in the event that we fail to pay an Out-of-Network pharmacy for prior authorized Prescription drugs occurring when you were actively enrolled in the Plan, you won't be liable for any sums owed by us.

We'll pay for certain drugs dispensed by an Out-of-Network pharmacy under certain circumstances, subject to the limitations contained in **Chapter 3**.

If you enter into a private contract with an Out-of-Network provider, neither the Plan nor Medicare will pay for those services.

SECTION 6 Non duplication of benefits with automobile, accident or liability coverage

If you're receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under state and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your drugs exceeds such coverage. You're required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your Plan membership.

SECTION 7 Contracting In-Network pharmacies

The relationships between us and our In-Network Pharmacy providers are independent contractor relationships. None of the In-Network Pharmacy providers or their pharmacists or employees are employees or agents of Express Scripts Medicare. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of Express Scripts Medicare is an employee or agent of the In-Network Pharmacy.

SECTION 8 Disclosure

HealthSelect Medicare Rx PDP is an Employer Prescription Drug Plan provided by ERS and administered by Express Scripts[®] Pharmacy Benefit Services, a Medicare-approved Part D sponsor. Enrollment in Express Scripts Medicare depends on Express Scripts Medicare's contract renewal with Medicare.

SECTION 9 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce benefits under this *Evidence of Coverage* or be used in defense of a legal action unless it is contained in a written application.

SECTION 10 Information upon request

As a Plan Member, you have the right to request information on general coverage and comparative plan information.

SECTION 11 Commitment of Coverage Decisions

Express Scripts Medicare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: (1) Do not specifically receive reward for issuing non-coverage (denial) decisions; (2) Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and (3) Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

CHAPTER 10: Definitions

Annual Enrollment Period – The time period of October 15 until December 7 of each year when Members can change their health or drug plans or switch to Original Medicare. This is separate from the ERS Fall Enrollment Period.

Appeal – An Appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called Biosimilars. Biosimilars generally work just as well, and are as safe as the Original Biological Products (go to **Original Biological Product** and **Biosimilar**).

Biosimilar – A Biological Product that is very similar, but not identical, to the Original Biological Product. Biosimilars are as safe and effective as the Original Biological Product. Some Biosimilars may be substituted for the Original Biological Product at the pharmacy without needing a new prescription (go to **Interchangeable Biosimilar**).

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,400 for Part D prescription drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs. **Cost sharing will still apply for drugs not normally covered by Medicare Part D that are covered by the enhanced benefits..**

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

Complaint – The formal name for making a Complaint is **filing a Grievance**. The Complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes Complaints if this Plan doesn't follow the time periods in the Appeal process.

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

Cost Sharing – Cost sharing refers to amounts that a Member has to pay when drugs are received. (This is in addition to the Plan's monthly Premium, if applicable.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount the Plan may have before drugs are covered and (2) any fixed Copayment amount that the Plan requires when a specific drug is received.

Cost-Sharing Tier (Drug Tier) – Each drug on our drug list is placed in a Cost-Sharing, or drug, tier – for example, Generic Drug tier. The amount you pay as a Copayment depends, in part, on which tier the drug is in. Find more information about tiers in your *Formulary (drug list)*. In general, the higher the Cost-Sharing Tier, the higher your cost for the drug.

Chapter 10

Coverage Determination – A decision about whether a drug prescribed for you is covered by the Plan and the amount, if any, you’re required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under the Plan, that isn’t a Coverage Determination. You need to call or write to the Plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by the 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 drug coverage later.

Customer Service – A dedicated team and phone number responsible for answering your questions about your membership, benefits and filing Grievances. The HealthSelect Medicare Rx PDP Customer Service phone number is **(866) 264-4676**.

Daily Cost-Sharing Rate – A Daily Cost-Sharing Rate may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you’re required to pay a Copayment. A Daily Cost-Sharing Rate is the Copayment divided by the number of days in a month’s supply. Here is an example: If your Copayment for a one-month supply of a drug is \$30, and a one-month’s supply in your Plan is 30 days, then your Daily Cost-Sharing Rate is \$1 per day.

Deductible – The amount you must pay for prescriptions before the Plan pays. The deductible resets annually.

Disenroll or Disenrollment – The process of ending your membership in the Plan. Your membership will end on the last day of the month in which we receive the request to disenroll from you, ERS, or Medicare.

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our *Formulary* (a *Formulary* Exception), or get a non-preferred drug at a lower Cost-Sharing level (a *tiering* Exception). You may also ask for an Exception if the Plan requires you to try another drug before getting the drug you’re asking for, if the Plan requires a Prior Authorization for a drug and you want us to waive the criteria restriction, or if the Plan limits the quantity or dosage of the drug you’re asking for (a *Formulary* Exception).

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

Chapter 10

Formulary or Drug List – A list of prescription drugs covered by the Plan.

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

Grievance – A type of Complaint you make about the Plan, providers, or pharmacies, including a Complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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

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

Initial Coverage Stage – This is the stage where you pay your cost-share for Part D drugs, until you reach \$2,400 in Out-of-Pocket costs.

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

In-Network Pharmacy – A pharmacy that contracts with the Plan where Members of the Plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

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

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

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

Chapter 10

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.

Medicare Beneficiary Identifier (MBI) – A Medicare Beneficiary Identifier (MBI) is the number on your red, white and blue Medicare ID card and is used for Medicare transactions like billing, eligibility and claims status. Every person with Medicare has been assigned an MBI.

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

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

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

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

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

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

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

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital, or other healthcare 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 the Plan to coordinate or provide Prescription drugs to Members of the Plan. Most drugs you get from Out-of-Network pharmacies aren't covered by the Plan unless certain conditions apply.

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Out-of-Pocket costs – Go to the definition for Cost Sharing above. A Member's Cost-Sharing requirement to pay for a portion of drugs received is also referred to as the Member's Out-of-Pocket cost requirement.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Part D Late Enrollment Penalty (LEP) – An amount added to your monthly Premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D Plan.

Plan – HealthSelect Medicare Rx Prescription Drug Plan (PDP), administered by Express Scripts[®] Pharmacy Benefit Services, as described within this document. For more information please go to HSMedicareRx.com.

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

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

Prior Authorization – A type of plan restriction requiring approval in advance to get certain drugs that may or may not be on our *Formulary*. Some drugs are covered only if your doctor or other In-Network provider gets prior Authorization from us. Prescription drugs that need Prior Authorization are marked in the *Formulary* and our criteria are posted on our website.

Quality Improvement Organization (QIO) – A group of practicing doctors and other healthcare experts paid by the federal government to check and improve the care given to Medicare patients.

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

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

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

Chapter 10

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

APPENDIX: Important phone numbers and resources

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711. The information in this Appendix is current as of 04/13/2026.		
State:	Agency Address \ Website:	Telephone \ Hours:
Alabama	State Health Insurance Assistance Program (SHIP) Alabama Department of Senior Services RSA Tower 201 Monroe Street, Suite 350 Montgomery, AL 36104 https://alabamaageline.gov/ship	Toll-free: 1.800.243.5463 Local: 1.334.242.5743 Mon. – Fri. 8 a.m. – 5 p.m.
Alaska	State Health Insurance Assistance Program (SHIP) Alaska Medicare Information Office 1835 Bragaw Street, Suite 350 Anchorage, AK 99508 https://health.alaska.gov/en/senior-and-disabilities-services/medicare-office/	Toll-free: 1.800.478.6065 <i>(in-state only)</i> Local: 1.907.269.3680 TTY: 1.800.770.8973 Mon. – Fri. 8 a.m. – 5 p.m. except holidays
Arizona	State Health Insurance Assistance Program (SHIP) Arizona Department of Economic Security DES Division of Aging and Adult Services 1789 West Jefferson Street, MC 6288 Phoenix, AZ 85007 https://des.az.gov/medicare-assistance	Toll-free: 1.800.432.4040 Local: 1.602.542.4446 Mon. – Fri. 8 a.m. – 5 p.m., except holidays
Arkansas	Senior Health Insurance Information Program Arkansas Insurance Department 1 Commerce Way Little Rock, AR 72202 https://insurance.arkansas.gov/pages/consumer-services/senior-health/	Toll-free: 1.800.224.6330 Local: 1.501.371.2782 Mon. – Fri. 8 a.m. – 4:30 p.m.
California	California Health Insurance Counseling and Advocacy Program (HICAP) California Department of Aging 2880 Gateway Oaks Drive, Suite 200 Sacramento, CA 95833 https://aging.ca.gov/Programs_and_Services/Medicare_Counseling	Toll-free: 1.800.434.0222 Mon. – Fri. 8 a.m. – 4p.m.

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State:	Agency Address \ Website:	Telephone \ Hours:
Colorado	Senior Health Insurance Assistance Program (SHIP) Colorado Division of Insurance 1560 Broadway, Suite 850 Denver, CO 80202 http://www.colorado.gov/pacific/dora/senior-healthcare-medicare	Toll-free: 1.888.696.7213 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Connecticut	CHOICES 55 Farmington Ave., 12th Floor Hartford, CT 06105 https://portal.ct.gov/ads/programs-and-services/choices?language=en_US	Toll-free: 1.800.994.9422 <i>(in-state only)</i> Local: 1.860.724.6443 TTY: 1.860.247.0775 Mon. – Fri. 8:30 a.m. – 4:30 p.m.
Delaware	Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street, Suite 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	Toll-free: 1.800.336.9500 Local: 1.302.674.7364 Mon. – Fri. 8 a.m. – 4:30 p.m.
District of Columbia	State Health Insurance Assistance Program 500 K Street, NE Washington, DC 20002 https://dacl.dc.gov	Local: 1.202.724.5626 TTY: 711 Mon. – Fri. 9:30 a.m. – 4:30 p.m.
Florida	SHINE Program Florida Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000 http://www.floridashine.org/	Toll-free: 1.800.963.5337 TTY/TDD: 1.800.955.8770 Mon. – Fri. 8 a.m. – 5 p.m.
Georgia	Georgia SHIP Georgia DHS Division of Aging Services 47 Trinity Ave., SW Atlanta, GA 30334 https://aging.georgia.gov/georgia-ship	Toll-free: 1.866.552.4464 <i>option #4</i> Local: 1.404.657.5258 Mon. – Fri. 8 a.m. – 5 p.m.

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State:	Agency Address \ Website:	Telephone \ Hours:
Guam	Division of Senior Citizens Guam 130 University Drive, Suite 8 University Castle Mall, Mangilao, Guam 96913 https://dphss.guam.gov/division-of-senior-citizens-2/	Local: 1.671.735.7421 TTY: 1.671.735.7415
Hawaii	Hawaii SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, HI 96813-2831 https://www.hawaiiiship.org	Toll-free: 1.888.875.9229 Local: 1.808.586.7299 TTY: 1.866.810.4379
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) Idaho Department of Insurance 700 West State Street, 3rd Floor P.O. Box 83720 Boise, ID 83720-0043 https://doi.idaho.gov/SHIBA/	Toll-free: 1.800.247.4422 Mon. – Fri. 8 a.m. – 5 p.m., except state holidays
Illinois	Senior Health Insurance Program (SHIP) Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271 https://ilaging.illinois.gov/ship.html	Toll-free: 1.800.252.8966 TTY: 711 Mon. – Fri. 8:30 a.m. – 5 p.m.
Indiana	State Health Insurance Assistance Program (SHIP) Indiana Department of Insurance 311 W. Washington Street, 2nd Floor Indianapolis, IN 46204-2787 https://www.in.gov/ship/	Toll-free: 1.800.452.4800 TDD: 1.866.846.0139 Mon. – Fri. 8 a.m. – 4:30 p.m.
Iowa	Senior Health Insurance Information Program (SHIIP) Iowa Insurance Division 1963 Bell Avenue, Suite 100 Des Moines, IA 50315 https://shiip.iowa.gov/	Toll-free: 1.800.351.4664 TTY: 1.800.735.2942 <i>(in-state only)</i> Mon. – Fri. 8 a.m. – 4:30 p.m., except state holidays

State Health Insurance Assistance Programs (SHIPs)		
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State:	Agency Address \ Website:	Telephone \ Hours:
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) Kansas Department for Aging and Disability Services New England Building 503 South Kansas Avenue Topeka, KS 66603-3404 https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick	Toll-free: 1.800.860.5260 Toll-free: 1.800.432.3535 <i>(in-state only)</i> TTY: 1.800.766.3777 Mon. – Fri. 8 a.m. – 5 p.m.
Kentucky	State Health Insurance Assistance Program (SHIP) Kentucky Cabinet for Health and Family Services Department for Aging and Independent Living 275 East Main Street 3 E-E Frankfort, KY 40601 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	Toll-free: 1.877.293.7447 <i>option #2</i> Local: 1.502.564.6930 TTY: 1.888.642.1137 Mon. – Fri. 8 a.m. – 4:30 p.m.
Louisiana	Senior Health Insurance Information Program (SHIIP) Louisiana Department of Insurance P.O. Box 94214 Baton Rouge, LA 70804 http://www.lda.la.gov/consumers/senior-health-shiip	Toll-free: 1.800.259.5300 or 1.800.259.5301 <i>(in-state only)</i> Local: 1.225.342.5301 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
Maine	State Health Insurance Assistance Program Office of Aging and Disability Services Maine Department of Health and Human Services 41 Anthony Avenue, #11 State House Station Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	Toll-free: 1.800.262.2232 Local: 1.207.287.9200 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	State Health Insurance Assistance Program (SHIP) Maryland Department of Aging 36 South Charles Street, 12th Floor Baltimore, MD 21201 https://aging.maryland.gov/Pages/State-Health-Insurance-Program.aspx	Toll-free: 1.800.243.3425 <i>(in-state only)</i> Local: 1.410.767.1100 TTY: 711 Mon. – Fri. 8:30 a.m. – 5 p.m.
Massachusetts	Serving the Health Information Needs of Everyone (SHINE) Program Executive Office of Aging and Independence One Ashburton Place, 10th Floor Boston, MA 02108 https://www.mass.gov/health-insurance-counseling	Toll-free: 1.800.243.4636 Local: 1.617.727.7750 TTY: 1.800.439.2370 Mon. – Fri. 9 a.m. – 5 p.m.

State Health Insurance Assistance Programs (SHIPs)		
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State:	Agency Address \ Website:	Telephone \ Hours:
Michigan	Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.) 6105 West St. Joseph Highway, Suite 204 Lansing, MI 48917 https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program	Toll-free: 1.800.803.7174 Mon. – Fri. 8 a.m. – 5 p.m.
Minnesota	Minnesota Aging Pathways 540 Cedar Street St. Paul, MN 55164 http://mn.gov/senior-linkage-line	Toll-free: 1.800.333.2433 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
Mississippi	State Health Insurance Assistance Program (SHIP) Mississippi Department of Human Services Division of Aging & Adult Services 200 South Lamar Street Jackson, MS 39201 https://www.mdhs.ms.gov/aging/finding-services-for-older-adults	Toll-free: 1.844.822.4622 Local: 1.601.359.4500 Mon. – Fri. 8 a.m. – 5 p.m.
Missouri	Missouri SHIP 601 W Nifong Blvd. Suite 3A Columbia, MO 65203 www.missouriship.org/	Toll-free: 1.800.390.3330 Local: 1.573.817.8300 Mon. – Fri. 9 a.m. – 4 p.m.
Montana	Montana State Health Insurance Assistance Program (SHIP) Senior and Long Term Care Division PO Box 4210 Helena, MT 59604 https://dphhs.mt.gov/SLTC/aging/SHIP	Toll-free: 1.800.551.3191 TTY: 1.800.253.4091 or 1.800.253.4093 Mon. – Fri. 8 a.m. – 5 p.m.
Nebraska	Nebraska State Health Insurance Assistance Program (SHIP) PO Box 95087 Lincoln, NE 68509-5087 https://doi.nebraska.gov/ship-smp	Toll-free: 1.800.234.7119 Mon. – Fri. 8 a.m. – 5 p.m.
Nevada	Nevada Medicare Assistance Program (MAP) 1550 College Parkway Carson City, NV 89706 https://www.nevadacareconnection.org/medicare-assistance-program-map/	Toll-free: 1.800.307.4444 Local: 1.775.687.4210

State Health Insurance Assistance Programs (SHIPs)		
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State:	Agency Address \ Website:	Telephone \ Hours:
New Hampshire	State Health Insurance Assistance Program 105 Pleasant Street Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/adult-aging-care/servicelink/servicelink-medicare-support-services	Toll-free: 1.866.634.9412 TTY: 711 Mon. – Fri. 8 a.m. – 4 p.m.
New Jersey	State Health Insurance Assistance Program (SHIP) New Jersey Department of Human Services Division of Aging Services P.O. Box 715 Trenton, NJ 08625-0715 https://nj.gov/humanservices/doas/services/q-z/ship	Toll-free: 1.800.792.8820 (<i>in-state only</i>) Mon. – Fri. 8:30 a.m. – 4:30 p.m. except for holidays
New Mexico	Benefits Counseling Program New Mexico Aging Services 2550 Cerillos Road Santa Fe, NM 87505 https://www.aging.nm.gov/consumer-and-elder-rights/medicare/	Toll-free: 1.800.432.2080 Local: 1.505.476.4799 TTY: 1.505.476.4937 Mon. – Fri. 8 a.m. – 5 p.m.
New York	Health Insurance Information, Counseling and Assistance Program (HIICAP) New York State Office for the Aging 2 Empire State Plaza, 5 th Floor Albany, NY 12223 https://aging.ny.gov/health-insurance-information-counseling-and-assistance	Toll-free: 1.800.701.0501 Mon. – Fri. 8:30 a.m. – 5 p.m.
North Carolina	Medicare and Seniors' Health Insurance Information Program (SHIIP) North Carolina Department of Insurance 1201 Mail Service Center Raleigh, NC 27699-1201 www.ncdoi.com/SHIIP/Default.aspx	Toll-free: 1.855.408.1212 Local: 1.919.807.6800 TTY: 1.800.735.2962 Mon. – Fri. 8 a.m. – 5 p.m.
North Dakota	State Health Insurance Assistance Program (SHIP) North Dakota Insurance & Securities Department 600 East Boulevard Avenue Bismarck, ND 58505-0320 www.nd.gov/ndins/shic	Toll-free: 1.888.575.6611 Local: 1.701.328.2440 TTY: 1.800.366.6888 Mon. – Thurs. 8 a.m. – 5 p.m. Fri 8 a.m. to noon, except state holidays

State Health Insurance Assistance Programs (SHIPs)		
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State:	Agency Address \ Website:	Telephone \ Hours:
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) Ohio Department of Insurance 50 West Town Street, Suite 300 Columbus, OH 43215 https://insurance.ohio.gov/consumers/medicare/01-oshiip	Toll-free: 1.800.686.1578 Local: 1.614.644.2673 Mon. – Fri. 7:30 a.m. – 5 p.m.
Oklahoma	Senior Health Insurance Counseling Program (SHIP) Oklahoma Insurance Department 400 NE 50th Street Oklahoma City, OK 73105 https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/	Toll-free: 1.800.763.2828 (in-state only) Out of state: 1.405.521.6628 Mon. – Fri. 8 a.m. – 5 p.m., except state holidays
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter Street NE Salem, OR 97309-0405 http://healthcare.oregon.gov/shiba/Pages/index.aspx	Toll-free: 1.800.722.4134 Local: 1.503.947.7979 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	Pennsylvania Medicare Education and Decision Insight PA MEDI Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 https://www.pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling	Toll-free: 1.800.783.7067 Local: 1.717.783.1550 Mon. – Fri. 8 a.m. – 5 p.m.
Puerto Rico	State Health Insurance Assistance Program (SHIP) Oficina del Procurador de las Personas de Edad Avanzada P.O. Box 191179 San Juan, PR 00919-1179 https://www.oppea.pr.gov/programas-y-servicios	Toll-free: 1.877.725.4300 Local: 1.787.721.6121 TTY: 1.787.919.7291
Rhode Island	Health Insurance Assistance Program (SHIP) Office of Healthy Aging 25 Howard Avenue, Bldg. 57 Cranston, RI 02920 https://oha.ri.gov/Medicare	Toll-free: 1.888.884.8721 Local: 1.401.462.3000 TTY: 1.401.462.0740 Mon. – Fri. 8:30 a.m. – 4 p.m.

State Health Insurance Assistance Programs (SHIPs)		
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
State:	Agency Address \ Website:	Telephone \ Hours:
South Carolina	South Carolina Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201 https://aging.sc.gov/	Toll-free: 1.800.868.9095 Local: 1.803.734.9900 Mon. – Fri. 8:30 a.m. – 5 p.m.
South Dakota	Senior Health Information and Insurance Education (SHIINE) South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501-2291 https://dhs.sd.gov/en/ltss/shiine	Toll-free: 1.800.536.8197 Local: 1.605.333.3314 Mon. – Fri. 8 a.m. – 4:30 p.m.
Tennessee	Tennessee State Health Insurance Assistance Program (TN SHIP) Tennessee Commission on Aging and Disability Andrew Jackson Building 315 Deaderick Street Nashville, TN 37243 https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html	Toll-free: 1.800.535.9725 Local: 1.615.532.6530 TTY: 1.800.848.0299 Mon. – Fri. 8 a.m. – 4:30 p.m.
Texas	Texas Health Information Counseling and Advocacy Program (HICAP) Texas Health and Human Services Commission North Austin Complex 4601 W. Guadalupe St. Austin, TX 78711-3247 https://hhs.texas.gov/services/health/medicare	Toll-free: 1.800.252.9240 TTY: 1.800.735.2989 Mon. – Fri. 8 a.m. – 5 p.m.
U.S. Virgin Islands	VI SHIP/Medicare 5049 Kongens Gade St. Thomas, VI 00802 VI SHIP/Medicare 1131 King Street, Suite 101 Christiansted, St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	Local: 1.340.774.2991 (<i>St. Thomas/St. John</i>) Local: 1.340.773.6449 (<i>St. Croix</i>) Mon. – Fri. 8 a.m. – 5 p.m.
Utah	Senior Health Insurance Information Program (SHIP) Aging and Adult Services of Utah 288 North 1460 West Salt Lake City, UT 84116 https://daas.utah.gov/seniors	Toll-free: 1.800.541.7735 Local: 1.801.538.3910 Mon. – Fri. 8 a.m. – 5 p.m.

State Health Insurance Assistance Programs (SHIPs)		
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
State:	Agency Address \ Website:	Telephone \ Hours:
Vermont	State Health Insurance Program (SHIP) Department of Disabilities, Aging and Independent Living Adult Services Division 280 State Drive, HC2 South Waterbury, VT 05671-2070 http://asd.vermont.gov/services/ship	Toll-free: 1.800.642.5119 (<i>in-state only</i>) Local: 1.802.241.0294 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) Department for Aging and Rehabilitative Services 5620 Cox Road Glen Allen, VA 23060 https://www.vda.virginia.gov/vicap.htm	Toll-free: 1.800.552.3402 Local: 1.804.662.9333 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 http://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/	Toll-free: 1.800.562.6900 TTY: 1.360.586.0241 Mon. – Fri. 8:30 a.m. – 4:30 p.m., except holidays
West Virginia	West Virginia State Health Insurance Assistance Program (WV SHIP) West Virginia Bureau of Senior Services 1900 Kanawha Boulevard East Charleston, WV 25305 http://www.wvship.org/AboutWVSHIP/tabid/132/Default.aspx	Toll-free: 1.877.987.4463 Local: 1.304.558.3317 Mon. – Fri. 8 a.m. – 5 p.m.
Wisconsin	State Health Insurance Assistance Program (SHIP) Wisconsin Department of Health Services 1 West Wilson Street Madison, WI 53703 https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	Toll-free: 1.800.242.1060 Local: 1.608.266.1865 TTY: 711 or 1.800.947.3529 Mon. – Fri. 8 a.m. – 4:30 p.m.
Wyoming	Wyoming State Health Insurance Information Program (WSHIP) 106 West Adams Avenue Riverton, WY 82501 http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	Toll-free: 1.800.856.4398 Local: 1.307.856.6880 Mon. – Fri. 8 a.m. – 4:30 p.m.

Quality Improvement Organizations		
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Region:	Agency Address \ Website:	Telephone \ Hours:
Region 1	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 https://www.acentraqio.com/	Toll-free: 1.888.319.8452 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 1 includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.		
Region 2	Commence Health BFCC-QIO P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/en	Toll-free: 1.866.815.5440 Puerto Rico Local: 1.787.520.5743 U.S. Virgin Islands Local: 1.340.773.6334 TTY: 711 Fax: 1.855.236.2423 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. and Holidays 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 2 includes New Jersey, New York, Puerto Rico and U.S. Virgin Islands.		
Region 3	Commence Health BFCC-QIO P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/en	Toll-free: 1.888.396.4646 TTY: 711 Fax: 1.855.236.2423 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. and Holidays 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 3 includes Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia.		

Quality Improvement Organizations		
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Region:	Agency Address \ Website:	Telephone \ Hours:
Region 4	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 https://www.acentraqio.com/	Toll-free: 1.888.317.0751 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 4 includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.		
Region 5	Commence Health BFCC-QIO P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/en	Toll-free: 1.888.524.9900 TTY: 711 Fax: 1.855.236.2423 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. and Holidays 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 5 includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.		
Region 6	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 https://www.acentraqio.com/	Toll-free: 1.888.315.0636 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 6 includes Arkansas, Louisiana, New Mexico, Oklahoma and Texas.		
Region 7	Commence Health BFCC-QIO P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/en	Toll-free: 1.888.755.5580 TTY: 711 Fax: 1.855.694.2929 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. and Holidays 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 7 includes Iowa, Kansas, Missouri and Nebraska.		

Quality Improvement Organizations		
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Region 8	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 https://www.acentraqio.com/	Toll-free: 1.888.317.0891 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 8 includes Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming.		
Region:	Agency Address \ Website:	Telephone \ Hours:
Region 9	Commence Health BFCC-QIO P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/en	Toll-free: 1.877.588.1123 American Samoa: 1.684.699.3330 Guam: 1.671.685.2689 Northern Mariana Islands: 1.670.989.2686 TTY: 711 Fax: 1.855.694.2929 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. and Holidays 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 9 includes American Samoa, Arizona, California, Guam, Hawaii, Nevada and Northern Mariana Islands.		
Region 10	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 https://www.acentraqio.com/	Toll-free: 1.888.305.6759 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 10 a.m. – 4 p.m., Local Time 24-hour voicemail is available
Region 10 includes Alaska, Idaho, Oregon and Washington.		

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711. The information in this Appendix is current as of 08/13/2026.		
State:	Agency Address \ Website:	Telephone \ Hours:
Alabama	Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov	Toll-free: 1.800.362.1504 Local: 1.334.242.5000 TTY: 1.800.253.0799 Mon. – Fri. 8 a.m. – 4:30 p.m.
Alaska	Alaska Department of Health and Social Services 3901 Old Seward Highway, Suite 131 Anchorage, AK 99503 https://health.alaska.gov	Toll-free: 1.800.478.7778 Mon. – Fri. 8 a.m. – 5 p.m. Closed weekends & holidays
American Samoa	American Samoa Medicaid State Agency ASTCA Executive Bldg., 3rd Floor P.O. Box 6101, Pago Pago, AS 96799 https://www.americansamoa.gov/agencies	Local: 1.684.699.4777 Mon – Fri 7:30 a.m. – 4 p.m.
Arizona	Arizona Health Care Cost Containment System (Arizona Medicaid Program) 801 East Jefferson Street Phoenix, AZ 85034 http://www.azahcccs.gov/	Toll-free: 1-800-654-8713 Local: 1.602.417.4000 TTY: 1.800.842.6520 Mon. – Fri. 8 a.m. – 5 p.m.
Arkansas	Division of Medical Services P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437 https://humanservices.arkansas.gov/divisions-shared-services/medical-services/contact-dms-2/	Toll-free: 1.800.482.8988 Local: 1.501.682.8233 Mon. – Fri. 8 a.m. – 4:30 p.m.
California	Medi-Cal Dept. of Health Care Services/Beneficiary Services Ctr. P.O. Box 13029 Sacramento, CA 95813-8008 http://www.dhcs.ca.gov	Toll-free: 1.800.541.5555 Mon. – Fri. 8 a.m. – 5 p.m.
Colorado	Department of Health Care Policy and Financing 303 E 17th Ave, Suite 1100 Denver, CO 80203 http://www.colorado.gov/hcpf	Toll-free: 1.800.221.3943 Local: 1.303.866.2993 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m. Closed holidays

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
Connecticut	HUSKY Health Program c/o Department of Social Services 55 Farmington Avenue Hartford, CT 06105 https://portal.ct.gov/oha/health-care-plans/other-plans/medicaid?language=en_US	Toll-free: 1.855.626.6632 TTY: 1.866.492.5276 Mon. – Fri. 8:30 a.m. – 4:30 p.m. Closed Weds.
Delaware	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 North DuPont Highway, Lewis Building New Castle, DE 19720 http://assist.dhss.delaware.gov/	Toll-free: 1.302.255.9500. Local: 1.302.571.4900 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
District of Columbia	DC Department of Health Care Finance 441 4th Street, NW, 900S Washington, DC 20001 http://dhcf.dc.gov/	Local: 1.202.442.5988 TTY: 711 Mon. – Fri. 8:15 a.m. – 4:45 p.m.
Florida	Florida Agency for Health Care Administration P.O. Box 5197, MS 62 Tallahassee, FL 32314 http://www.flmedicaidmanagedcare.com/	Toll-free: 1.877.711.3662 TDD: 1.866.467.4970 Mon. – Thu. 8 a.m. – 8 p.m. Fri. 8 a.m. – 7 p.m.
Georgia	Georgia Department of Community Health 2 Martin Luther King, Jr. Drive SE East Tower Atlanta, GA 30334 https://medicaid.georgia.gov	Toll-free: 1.877.423.4746 Local: 1.404.657.5468 Mon. – Fri. 8:00 a.m. – 5:00 p.m.
Guam	Department of Public Health and Social Services 123 Chalan Kareta Mangilao, GU 96913 http://www.dphss.guam.gov/	Local: 1.671.735.7305 Mon. – Fri. 8 a.m. – 5 p.m.

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
Hawaii	Med-QUEST P.O. Box 3490 Honolulu, HI 96811 https://medquest.hawaii.gov/	Local: 1.808.524.3370 TTY/TDD: 711 (Oahu) Toll-free: 1.800.316.8005 TTY/TDD: 711 (Neighbor Islands) Mon. – Fri. 7:45 a.m. – 4:30 p.m. Closed holidays
Idaho	Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov	Local: 1.877.456.1233 TTY/TDD: 1.208.332.7205 Mon. – Fri. 8 a.m. – 5 p.m.
Illinois	Illinois Department of Human Services Administrative Offices 100 South Grand Avenue East Springfield, IL 62704 https://www.dhs.state.il.us/page.aspx	Toll-free: 1.800.843.6154 TTY: 1.888.440.8994 Mon. – Fri. 8:30 a.m. – 5 p.m. Closed on State holidays
Indiana	Family and Social Services Administration Office of Medicaid Policy and Planning 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46204 http://www.in.gov/medicaid/members/	Toll-free: 1.800.403.0864 Mon. – Fri. 8 a.m. – 4:30 p.m. Closed holidays
Iowa	Iowa Medicaid Enterprise Department of Human Services – Member Services P.O. Box 36510 Des Moines, IA 50315 http://dhs.iowa.gov/iahealthlink	Toll-free: 1.800.338.8366 Local: 1.515.256.4606 TTY: 1.800.735.2942 Mon. – Fri. 8:00 a.m. – 5:00 p.m.
Kansas	Kansas Medical Assistance Program P.O. Box 3571 Topeka, KS 66601 http://www.kancare.ks.gov/	Toll-free: 1.800.792.4884 TTY: 1.800.766.3777 Mon. – Fri. 8:00 a.m. – 5:00 p.m.

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
Kentucky	Department for Medicaid Services 275 East Main Street 6EC Frankfort, KY 40621 http://chfs.ky.gov/agencies/dms/Pages/default.aspx	Toll-free: 1.800.635.2570 Local: 1.502.564.4321 Mon. – Fri. 8:00 a.m. – 7:00 p.m.
Louisiana	Department of Health P.O. Box 629 Baton Rouge, LA 70821-0629 http://www.dhh.louisiana.gov	Toll-free: 1.888.342.6207 Local: 1.225.342.9500 Mon. – Fri. 8:00 a.m. – 4:30 p.m.
Maine	Department of Health and Human Services 109 Capitol Street, 11 State House Station Augusta, ME 04333 http://mainecare.maine.gov	Toll-free: 1.866.690.5585 TTY: 711 Mon. – Fri. 7:00 a.m. – 6:00 p.m.
Maryland	Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201 https://health.maryland.gov/mmcp/provider/Pages/default.aspx	Toll-free: 1.877.463.3464 Local: 1.410.767.6500 Mon. – Fri. 8:30 a.m. – 5 p.m.
Massachusetts	MassHealth Office of Medicaid 100 Hancock St., 1 st Floor Quincy, MA 02171 http://www.mass.gov/masshealth	Toll-free: 1.800.841.2900 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m. Closed holidays
Michigan	Michigan Department of Health and Human Services Medicaid Program 333 S. Grand Avenue P.O. Box 30195 Lansing, MI 48909 www.michigan.gov/medicaid	Toll-free: 1.800.642.3195 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Minnesota	Department of Human Services Health Care Eligibility and Access Division P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs	Toll-free: 1.800.657-3672 Local: 1.651.431.2000 TTY: 1.800.627.3529 Mon. – Fri. 8 a.m. – 4:15 p.m.

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
Mississippi	Mississippi Division of Medicaid Sillers Building 550 High Street, Suite 1000 Jackson, MS 39201 http://www.medicaid.ms.gov	Toll-free: 1.800.421.2408 Local: 1.601.359.6050 Mon. – Fri. 7:30 a.m. – 5 p.m.
Missouri	The State of Missouri MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 http://dss.mo.gov/mhd	Toll-free: 1.800.392.2161 Local: 1.573.751.3425 TTY: 1.800.735.2966 or 711 Mon. – Fri. 8:00 a.m. – 5:00 p.m.
Montana	Department of Public Health and Human Services Health Resources Division P.O. Box 202925 Helena, MT 59601-5231 https://www.dphhs.mt.gov/MontanaHealthcarePrograms/	Toll-free: 1.888.706.1535 Local: (406) 444-5622 TTY: 711 Mon. – Fri. 7 a.m. – 5 p.m. Closed holidays
Nebraska	Nebraska Department of Health and Human Services P.O. Box 95026 Lincoln, NE 68509-5026 https://dhhs.ne.gov/Pages/Medicaid-Clients.aspx	Toll-free: 1.855.632.7633 Local: 1.402.473.7000 (Lincoln) Local: 1.402.595.1178 (Omaha) TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Nevada	Department of Health and Human Services Division of Health Care Financing and Policy 1100 East William Street, Suite 102 Carson City, NV 89701 http://dhcfp.nv.gov/	Toll-free: 1.877.638.3472 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
New Hampshire	Department of Health and Human Services Office of Medicaid Business and Policy 129 Pleasant Street Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/medicaid	Toll-free: 1.844.275.3447 Local: 1.603.271.9700 TDD: 1.800.735.2964 Mon. – Fri. 8 a.m. – 4 p.m.

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
New Jersey	New Jersey Department of Human Services Division of Medical Assistance and Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.nj.gov/humanservices/dmahs/clients/medicaid/	Toll-free: 1.800.701.0710 TTY: 711 Mon. – Thu. 8 a.m. – 8p.m. Tuesday, Wednesday, Friday 8 a.m. – 5 p.m.
New Mexico	NM Human Services Department Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504-2348 https://yes.nm.gov/nmhr/s/yesnm-health-and-benefits?language=en_US	Toll-free: 1.800.283.4465 TTY: 711 Mon.-Fri. 7:00 a.m. - 6:30 p.m.
New York	New York State Department of Health Corning Tower Empire State Plaza Albany, NY 12237 https://www.health.ny.gov/health_care/medicaid/	Toll-free: 1.800.541.2831 TTY: 1.800.662.1220 Mon. – Fri. 8 a.m. – 8 p.m. Sat. 9 a.m. – 1 p.m. Closed holidays
North Carolina	North Carolina Medicaid Division of Health Benefits 2501 Mail Service Center Raleigh, NC 27699-2501 https://medicaid.ncdhhs.gov/	Toll-free: 1.888.245.0179 Mon. – Fri. 8 a.m. – 5 p.m. Closed holidays
North Dakota	Medical Services Division North Dakota Department of Human Services 600 East Boulevard Avenue, Department 325 Bismarck, ND 58505-0250 https://www.hhs.nd.gov/healthcare/medicaid	Toll-free: 1.800.472.2622 Local: 1.701.328.2310 TTY: 1.800.366.6888 Mon. – Fri. 8 a.m. – 5 p.m. CT (holidays may affect these times)
Northern Mariana Islands	CNMI State Medicaid Agency Government Bldg. No. 1252 Capitol Hill Rd. Caller Box 10007 Saipan, MP 96950 https://www.cnmimedicaid.org/	Local: 1.670.664.4880 Mon. – Thu. 7:30 a.m. – 1 p.m. Closed Friday and holidays
Ohio	Department of Medicaid 50 West Town Street, Suite 400 Columbus, OH 43215 http://medicaid.ohio.gov/	Toll-free: 1.800.324.8680 Mon. – Fri. 8 a.m. – 8 p.m. Sat. 8 a.m. – 5 p.m.

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
Oklahoma	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105 http://okhca.org/	Toll-free: 1.800.987.7767 Local: 1.405.522.7300 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Oregon	Oregon Health Authority Health Systems Division 500 Summer Street, NE, E-20 Salem, OR 97301-1097 http://www.oregon.gov/oha/Pages/Contact-Us.aspx	Toll-free: 1.800.273.0557 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	Department of Human Services Office of Medical Assistance Programs P.O. Box 2675 Harrisburg, PA 17105-2675 https://www.pa.gov/agencies/dhs/resources/medicaid	Toll-free: 1.800.537.8862 TTY: 711 Mon. – Fri. 8:30 a.m. – 4:45 p.m., excluding holidays
Puerto Rico	Programa Medicaid Departamento de Salud P.O. Box 70184 San Juan, PR 00936-8184 http://medicaid.pr.gov	Local: 1.787.641.4224 TTY: 1.787.625.6955 Mon. – Fri. 8 a.m. – 5 p.m.
Rhode Island	Rhode Island Department of Human Services P.O. Box 8709 Cranston, RI 02920-8787 https://dhs.ri.gov/programs-and-services/medicaid-medicare-programs	Local: 1.855.697.4347 TTY: 711 Mon. – Fri. 8:30 a.m. – 4 p.m. Closed holidays
South Carolina	Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov	Toll-free: 1.888.549.0820 TTY: 1.888.842.3620 Mon. – Fri. 8 a.m. – 6 p.m.

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
South Dakota	Department of Social Services Attn: Medicaid 700 Governors Drive Pierre, SD 57501 https://dss.sd.gov/medicaid/default.aspx	Local: 1.605.773.4678 Local: 1.605.668.3100 Mon. – Fri. 8 a.m. – 5 p.m.
Tennessee	TennCare 310 Great Circle Road Nashville, TN 37243 https://www.tn.gov/tenncare/members-applicants/eligibility/tenncare-medicaid.html	Toll-free: 1.855.259.0701 Toll-free: 1.800.342.3145 Main line TTY: 1.877.779.3103 Mon. – Fri. 7 a.m. – 6 p.m., CT.
Texas	Texas Health and Human Services Commission P.O. Box 13247 Austin, TX 78711-3247 https://www.hhs.texas.gov/services/health/medicaid-chip	Toll-free: 1.800.335.8957 TTY: 711 Mon. – Fri. 7 a.m. – 7 p.m.
U.S. Virgin Islands	VI Medicaid Program Department of Human Services Knud Hansen Complex 1303 Hospital Ground, Bldg. A St. Thomas, VI 00802 VI Medicaid Program Department of Human Services 3011 Golden Rock, Christiansted St. Croix, VI 00820 http://www.vimmis.com/default.aspx	Local: 1.340.715.6929 Mon. – Fri. 7 a.m. – 7 p.m. Eastern Standard Time
Utah	Utah Department of Health and Human Services Division of Integrated Healthcare P.O. Box 143106 Salt Lake City, UT 84114-3106 http://medicaid.utah.gov/	Toll-free: 1.800.662.9651 Local: 1.801.538.6155 (Salt Lake City area) Mon. – Fri. 8 a.m. – 5 p.m. Tues. 11 a.m. – 5 p.m. Closed holidays
Vermont	Green Mountain Care Health Access Member Services Department of Vermont Health Access 280 State Drive, NOB 1 South Waterbury, VT 05671-1010 https://dvha.vermont.gov/members/medicaid	Toll-free: 1.800.464.4343 Local: 1.800.250.8427 TTY: 711 Mon. – Fri. 7:45 a.m. – 4:30 p.m. Closed holidays

State Medicaid Offices		
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State:	Agency Address \ Website:	Telephone \ Hours:
Virginia	Department of Medical Assistance Services 600 East Broad Street Richmond, VA 23219 https://www.dmas.virginia.gov/	Toll-free: 1.855.242.8282 TDD: 1.888.221.1590 Mon. – Fri. 8:00 a.m. – 7 p.m.
Washington	Washington State Health Care Authority Cherry Street Plaza 626 8th Avenue SE Olympia, WA 98501 http://www.hca.wa.gov/medicaid/Pages/index.aspx	Toll-free: 1.800.562.3022 TTY: 711 Mon. – Fri. 7 a.m. – 5 p.m. Closed holidays
West Virginia	Department of Health and Human Resources Bureau for Medical Services 350 Capitol Street, Room 251 Charleston, WV 25301 https://bms.wv.gov/	Local: 1.304.558.1700 Mon. – Fri. 8:30 a.m. - 4:30 p.m.
Wisconsin	Department of Health Services 201 E. Washington Ave. Madison, WI 53703 https://www.dhs.wisconsin.gov/medicaid/index.htm	Toll-free: 1.608.266.1865 TTY: 711 Mon. – Fri. 7:45 a.m. - 4:30 p.m.
Wyoming	Wyoming Department of Health 122 W 25th St., 4th Floor West Cheyenne, WY 82002 https://health.wyo.gov/healthcarefin/medicaid	Local: 1.855.294.2127 Mon. – Fri. 8 a.m. – 5 p.m. Closed holidays

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711. The information in this Appendix is current as of 05/27/2026.		
State:	Agency Address \ Website:	Telephone \ Hours:
Delaware	Delaware Prescription Assistance Program (DPAP) P.O. Box 950 New Castle, DE 19720-0950 http://dhss.delaware.gov/dhss/dmma/dpap.html	Toll-free: 1.844.245.9580 <i>(option 0)</i> Mon. – Fri. 8 a.m. – 4:30 p.m.
Indiana	HoosierRx: Indiana’s State Pharmaceutical Assistance Program Indiana State Department of Health 402 W. Washington Street Room 372, Indianapolis, IN 46204 http://IN.gov/HoosierRX	Toll-free: 1.866.267.4679 Mon. – Fri. 9 a.m. – 4 p.m.
Maine	Low Cost Drugs for the Elderly and Disabled Program (DEL) Office of Aging & Disability Services Maine Department of Health and Human Services 11 State House Station 41 Anthony Avenue Augusta, ME 04333 https://www.maine.gov/dhhs/ofi/programs-services	Toll-free: 1.800.262.2232 Local: 1.207.287.9200 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o International Software Systems, Inc. P.O. Box 749 Greenbelt, MD 20768-0749 http://marylandspdap.com	Toll-free: 1.800.551.5995 TTY: 1.800.877.5156 Mon. – Fri. 8 a.m. – 5 p.m.
Massachusetts	Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153 www.prescriptionadvantagemma.org	Toll-free: 1.800.243.4636 TTY: 711 Mon. – Fri. 9 a.m. – 5 p.m.
Missouri	Missouri Rx Plan (MORx) MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 https://mydss.mo.gov/mhd/providers	Local: 1.573.751.3425 Mon. – Fri. 8 a.m. – 5 p.m.

State Pharmaceutical Assistance Programs (SPAPs)		
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711. The information in this Appendix is current as of 05/30/2026		
State:	Agency Address \ Website:	Telephone \ Hours:
New Jersey	New Jersey Department of Human Services Pharmaceutical Assistance to the Aged and Disabled (PAAD), Lifeline and Special Benefit Programs Senior Gold Prescription Discount Program (Senior Gold) P.O. Box 715 Trenton, NJ 08625-0715 https://www.nj.gov/humanservices/doas/services/l-p/njsave/index.shtml	Toll-free: 1.800.792.9745 24 hours/7 days, automated system
New Mexico	New Mexico Medical Insurance Pool and New Mexico SPAP Program (NMMIP SPAP) P.O. Box 780548 San Antonio, TX 78278 https://nmmip.org/	Toll Free: 1.866.306.1882 Local: 1.505.424.7105 Mon. – Fri. 8 a.m. – 5 p.m.
New York	Elderly Pharmaceutical Insurance Coverage (EPIC) New York State Department of Health P.O. Box 15018 Albany, NY 12212-5018 www.health.ny.gov/health_care/epic/	Toll-free: 1.800.332.3742 TTY: 1.800.290.9138 Mon. – Fri. 8 a.m. – 5 p.m.
North Dakota	North Dakota Board of Pharmacy 1838 E Interstate Avenue, Suite D Bismark, ND 58503 https://www.nodakpharmacy.com/PDRP-index.asp	Local: 701.877.2404 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	PACE/PACENET Program Bureau of Pharmaceutical Assistance P.O. Box 8806 Harrisburg, PA 17105-8806 https://pacecares.primetherapeutics.com/	Toll-free: 1.800.225.7223 TTY: 1.800.222.9004 Mon. – Fri. 8:30 a.m. – 5 p.m.
Rhode Island	R.I. Pharmaceutical Assistance to Elders (RIPAE) Program Attn: RIPAE, Rhode Island Department of Human Services Office of Healthy Aging 25 Howard Avenue, Building 57 Cranston, RI 02920 https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance	Local: 1.401.462.3000 TTY: 1.401.462.0740 Mon. – Fri. 8:30 a.m. – 4 p.m.

State Pharmaceutical Assistance Programs (SPAPs)		
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
State:	Agency Address \ Website:	Telephone \ Hours:
Texas	Kidney Health Care Program (KHC) Office of Primary and Specialty Health, MC 1938 Mail Code 1938 P.O. Box 149030 Austin, TX 78714-9947 https://www.hhs.texas.gov/services/health/chronic-kidney-disease/kidney-health-care	Toll-free: 1.800.222.3986 Local: 1.512.776.7150 TTY: 1.800.735.2989 or 711 Mon. – Fri. 8 a.m. – 5 p.m.
Vermont	VPharm/Healthy Vermonters Green Mountain Care Department of Vermont Health Access 280 State Drive, NOB 1 South Waterbury, VT 05671-1500 https://dvha.vermont.gov/members/prescription-assistance	Toll-free: 1.800.250.8427 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
Wisconsin	Wisconsin SeniorCare PO Box 6710 Madison, WI 53716-0710 www.dhs.wisconsin.gov/seniorcare	Toll-free: 1.800.657.2038 TTY: 711 Mon. – Fri. 8 a.m. – 6 p.m.

AIDS Drug Assistance Programs TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711. The information in this Appendix is current as of 08/13/2026.		
State:	Agency Address \ Website:	Telephone \ Hours:
Alabama	Alabama AIDS Drug Assistance Program, Office of HIV Prevention and Care Alabama Department of Public Health The RSA Tower 201 Monroe Street Suite 1200 Montgomery, AL 36104 http://www.alabamapublichealth.gov/hiv/adap.html	Toll-free: 1.866.574.9964 Mon. – Fri. 8 a.m. – 5 p.m. (except state holidays)
Alaska	Alaskan AIDS Assistance Association 1057 W. Fireweed Lane, Suite 102 Anchorage, AK 99503 http://www.alaskanids.org/index.php/client-services/adap	Local: 1.907.263.2050 Mon. – Fri. 9 a.m. – 5 p.m.
American Samoa	Department of Public Health LBJ Tropical Medical Center P.O. Box F Pago Pago, AS 96799 https://nastad.org/sites/default/files/2024-06/NASTAD%20Membership%20Directory%20as%20of%206_24_2024.pdf	Local: 1.202.434.8090 Local: 011 (684) 633.1433 (in-state only)
Arizona	Arizona Department of Health Services 150 N. 18th Avenue, Suite 110 Phoenix, AZ 85007 https://www.azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/?index.php%23aids-drug-assistance-program-home#aids-drug-assistance-program-home	Toll-free: 1.800.334.1540 Local: 1.602.364.3610 Mon. – Fri. 8 a.m. – 5 p.m. (except state holidays)
Arkansas	Arkansas Department of Health, Infectious Disease Branch 4815 West Markham Street, Slot 33 Little Rock, AR 72205 https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/	Toll-free: 1.800.462.0599 Local: 1.501.661.2408 Mon. – Fri. 8 a.m. – 4:30 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
California	California Department of Public Health, Center for Infectious Diseases, Office of AIDS MS 0500, P.O. Box 997377 Sacramento, CA 95899-7377 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	Toll-free: 1.844.421.7050 Mon. – Fri. 8 a.m. – 5 p.m. (excluding holidays)
Colorado	State Drug Assistance Program (SDAP) – Colorado’s AIDS Drug Assistance Program (ADAP) Colorado Department of Public Health & Environment 4300 Cherry Creek Drive South Denver, CO 80246 https://www.colorado.gov/pacific/cdphe/state-drug-assistance-program	Local: 1.303.692.2716 Mon. – Fri. 9 a.m. – 5 p.m.
Connecticut	Connecticut AIDS Drug Assistance Program (CADAP) Connecticut Department of Public Health c/o Prime Therapeutics P.O. Box 13001 Albany, NY 12212-3001 https://ctdph.primetherapeutics.com/	Toll-free: 1.800.424.3310 Mon. – Fri. 8 a.m. – 4 p.m.
Delaware	Delaware ADAP Thomas Collins Building 540 S. DuPont Highway Dover, DE 19901 http://www.ramsellcorp.com/medical_professionals/de.aspx	Local: 1.302.744.1050 Mon. – Fri. 8 a.m. – 4:30 p.m.
District of Columbia	DC Pharmacy Benefits Program District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration, AIDS Drugs Assistance Program 899 North Capitol Street, NE Washington, DC 20002 https://dchealth.dc.gov/Pharmacy_Benefits_Program	Local: 1.202.671.4815 TTY: 711 Mon. – Fri. 8:15 a.m. – 4:45 p.m. (except District holidays)
Florida	Florida Department of Health HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	Toll-free: 1.850.245.4422 Mon. – Fri. 8 a.m. – 5 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
Georgia	Georgia Department of Public Health Office of HIV/AIDS 2 Peachtree Street, NW Atlanta, GA 30303 https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap	Local: 1.404.656.9805 Mon. – Fri. 8 a.m. – 5 p.m.
Guam	Department of Public Health and Social Services, Bureau of Communicable Disease Control Ryan White HIV/AIDS Office 520 West Santa Monica Avenue Dededo, GU 96929 https://dphss.guam.gov/dphss-programs/ryan-white-hiv-aids-program-rwha	Local: 1.671.735.3603 Mon. – Fri. 8 a.m. – 5 p.m.
Hawaii	Hawaii Department of Health Harm Reduction Services Branch HIV Medical Management Services 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816 https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/	Local: 1.808.733.9360 TTY: 711 Mon. – Fri. 7:45 a.m. – 4:30 p.m. (except state holidays)
Idaho	Idaho AIDS Drug Assistance Program Department of Health and Welfare Idaho Ryan White Part B Program 450 West State Street, 4th Floor P.O. Box 83720 Boise, ID 83720-0036 https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv	Toll-free: 1.800.926.2588 Local: 211 TTY/TDD: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Illinois	Illinois Department of Public Health Ryan White Part B Program 525 W. Jefferson Street, 1st Floor Springfield, IL 62761 https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services	Toll-free: 1.800.825.3518 Local: 1.217.524.5983 TTY: 1.800.547.0466 Mon. – Fri. 10 a.m. – 3 p.m.
Indiana	Indiana Department of Health 2 North Meridian Street, Suite 6C Indianapolis, IN 46204 https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/	Toll free: 1.866.588.4948 Local: 1.317.234.1811 Mon. – Fri. 8:15 a.m. – 4:45 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
Iowa	Iowa Benefits and Drug Assistance Program (BDAP) Iowa Department of Public Health 321 East 12th Street Des Moines, IA 50319-0075 https://hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program	Local: 1.515.204.3746 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Kansas	Kansas Department of Health & Environment 1000 SW Jackson Street, Suite 210 Topeka, KS 66612 https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program	Local: 1.785.296.6174 Mon. – Fri. 8 a.m. – 5 p.m.
Kentucky	Kentucky Department for Public Health Cabinet for Health and Family Services HIV/AIDS Branch 275 East Main Street, HS2E-C Frankfort, KY 40621 https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	Toll-free: 1.866.510.0005 Local: 1.502.564.6356 Mon. – Fri. 8 a.m. – 4:30 p.m.
Louisiana	Louisiana Office of Public Health 1450 Poydras Street, Suite 2136 New Orleans, LA 70112 https://www.lahap.org/	Local: 1.504.568.7474 Mon. – Fri. 8 a.m. – 4:30 p.m.
Maine	ADAP 40 State House Station Augusta, ME 04330 https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/ryan-white-b.shtml	Toll-free: 1.800.821.5821 Local: 1.207.287.3747 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	Maryland Department of Health Maryland AIDS Drug Assistance Program (MADAP) 1223 W. Pratt Street Baltimore, MD 21223 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx	Toll-free: 1.800.205.6308 Local: 1.410.767.6535 TTY: 1.800.735.2258 Mon. – Fri. 8:30 a.m. – 4:30 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
Massachusetts	Community Resource Initiative Attn: HDAP The Schrafft's City Center 529 Main Street, Suite 301 Boston, MA 02129 https://crihealth.org/drug-assistance/hdap/	Toll-free: 1.800.228.2714 Local: 1.617.502.1700 (option 1) Mon. – Fri. 9 a.m. – 5 p.m.
Michigan	Michigan Drug Assistance Program (MIDAP) HIV Care Section Division of HIV/STI Programs, Client, and Partner Services Bureau of HIV and STI Programs Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909 https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program/michigan-drug-assistance-program	Toll-free: 1.888.826.6565 Mon. – Fri. 9 a.m. – 5 p.m.
Minnesota	HIV Programs Department of Human Services P.O. Box 64972 St. Paul, MN 55164-0972 https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp	Toll-free: 1.800.657.3761 Local: 1.651.431.2414 TTY: 711 or 1.800.627.3529 Mon. – Fri. 9 a.m. – 5 p.m.
Mississippi	Mississippi State Department of Health Office of STD/HIV Care and Treatment Division P.O. Box 1700 Jackson, MS 39215-1700 https://msdh.ms.gov/msdhsite/_static/14,13047,150.html#adap	Toll-free: 1.888.343.7373 Local: 1.601.362.4879 Mon. – Fri. 8 a.m. – 5 p.m.
Missouri	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102-0570 https://health.mo.gov/living/healthcondiseases/communicable/hiv-aids/casemgmt.php	Toll-free: 1.888.252.8045 Local: 1.573.751.6439 TTY: 1.800.735.2966 Mon. – Fri. 8 a.m. – 5 p.m.
Montana	Montana Dept. of Public Health and Human Services Cogswell Bldg., Room C-211 1400 Broadway Helena, MT 59620-2951 https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog	Local: 1.406.444.3565 Mon. – Fri. 8 a.m. – 5 p.m., MST

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
Nebraska	Nebraska Department of Health & Human Services Ryan White Program P.O. Box 95026 Lincoln, NE 68509-5026 https://dhhs.ne.gov/Pages/HIV-Care.aspx	Local: 1.402.471.2101 Mon. – Fri. 8 a.m. – 5 p.m.
Nevada	Nevada Medication Assistance Program (NMAP), AIDS Drug Assistance Program (ADAP) Nevada Department of Health and Human Services 2290 S. Jones Blvd Suite 110 Las Vegas, NV 89146 https://endhivnevada.org/adap-nmap/	Local: 1.702.486.0767 Toll-free: 1.888.475.3219 Local: 1.406.444.4744 Mon. – Fri. 8 a.m. – 5 p.m.
New Hampshire	New Hampshire Department of Health & Human Services NH CARE Program 29 Hazen Drive Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap	Toll-free: 1.800.852.3345 <i>(in-state only)</i> Local: 1.603.271.4502 <i>extension 4502</i> TTY: 1.800.735.2964 Mon. – Fri. 8 a.m. – 4:30 p.m.
New Jersey	New Jersey Department of Health AIDS Drug Distribution Program (ADDP) P.O. Box 722 Trenton, NJ 08625-0722 http://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml	Toll-free: 1.877.613.4533 Mon. – Fri. 8:45 a.m. – 4:15 p.m.
New Mexico	New Mexico Department of Health HIV Services Program Harold Runnels Building 1190 St. Francis Drive, Suite S-1200 Santa Fe, NM 87502 https://nmhealth.org/about/phd/idb/hats/	Toll-free: 1.833.796.8773 Mon. – Fri. 8 a.m. – 5 p.m.
New York	Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220-0052 https://www.health.ny.gov/diseases/aids/general/resources/adap/	Toll-free: 1.800.542.2437 or 1.844.682.4058 <i>(in-state only)</i> Out-of-state: 1.518.459.1641 Mon. – Fri. 9 a.m. – 5 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
North Carolina	Communicable Disease Branch Epidemiology Section, Division of Public Health N.C. Dept. of Health and Human Services 1907 Mail Service Center Raleigh, NC 27699-1907 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	Toll-free: 1.877.466.2232 <i>(in-state only)</i> Local: 1.919.733.9161 Mon. – Fri. 8 a.m. – 5 p.m.
North Dakota	North Dakota AIDS Drug Assistance Program (ADAP) 600 East Boulevard Avenue Bismarck, ND 58505-0250 https://www.hhs.nd.gov/health/diseases-conditions-and-immunization/north-dakota-ryan-white-part-b-program	Toll-free: 1.800.472.2180 <i>(in-state only)</i> Local: 1.701.328.2378 TTY: 1.800.366.6888 or 711 Mon. – Fri. 8 a.m. – 5 p.m., CT.
Northern Mariana Islands	HIV/STD/VH Prevention Program P.O. Box 500409 Saipan, MP 96950 https://nastad.org/member-directory/jurisdictions?id=530	Local: 1.670.664.4050 Mon. – Fri. 7:30 (CHST) – 16:30 (CHST)
Ohio	Ohio HIV Drug Assistance Program (OHDAP) Ohio Department of Health 246 N High St, 2 nd Floor Columbus, OH 43215 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/	Toll-free: 1.800.777.4775 Mon. – Fri. 8 a.m. – 5 p.m.
Oklahoma	HIV/Sexual Health and Harm Reduction Services Oklahoma State Department of Health 123 Robert S. Kerr Ave., Suite. 1702 Oklahoma City, OK 73102-6406 https://oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.html	Local: 1.405.426.8400 Mon. – Fri. 8 a.m. – 5 p.m. (except holidays)
Oregon	CAREAssist Program 800 NE Oregon Street, Suite 1105 Portland, OR 97232 https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	Toll-free: 1.800.805.2313 Local: 1.971.673.0144 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
Pennsylvania	Department of Health Special Pharmaceutical Benefits Program P.O. Box 8808 Harrisburg, PA 17105-8808 https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	Toll-free: 1.800.922.9384 Mon. – Fri. 8 a.m. – 4:00 p.m.
Puerto Rico	Commonwealth of Puerto Rico Department of Health Ryan White Part B AIDS Drug Assistance Program P.O. Box 70184 San Juan, PR 00936-8184 https://www.salud.pr.gov/CMS/137	Local: 1.787.765.2929 Mon. – Fri. 8 a.m. – 4:30 p.m.
Rhode Island	Executive Office of Health and Human Services Office of HIV/AIDS Virks Building, Suite 227 3 West Road Cranston, RI 02920 https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	Local: 1.401.462.3295 Mon. – Fri. a.m. – 4 p.m.
South Carolina	South Carolina AIDS Drug Assistance Program Department of Public Health 400 Otarre Parkway Cayce, SC 29033-3751 https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	Toll-free: 1.800.856.9954 Mon. – Fri. 8:30 a.m. – 5 p.m.
South Dakota	South Dakota Department of Health Ryan White Part B CARE Program 615 East 4th Street Pierre, SD 57501-1700 https://doh.sd.gov/topics/diseases/infectious/reportable-communicable-diseases/hivaids/ryan-white-part-b-program/	Toll-free: 1.800.592.1861 Local: 1.605.773.3737 Mon. – Fri. 8 a.m. – 5 p.m.

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
Tennessee	Tennessee AIDS Drug Assistance Program (ADAP) Tennessee Department of Health 710 James Robertson Parkway Nashville, TN 37243 https://www.tn.gov/health/rwb.html	Toll-free: 1.800.525.2437 Local: 1.615.741.7500 Mon. – Fri. 7:00 a.m. – 4:30 p.m.
Texas	Texas HIV Medication Program ATTN: MSJA, MC 1873 Post Office Box 149347 Austin, TX 78714-9347 https://www.dshs.texas.gov/hivstd/meds	Toll-free: 1.800.255.1090 TTY: 1.800.735.2989 Mon. – Fri. 8 a.m. – 5 p.m.
U.S. Virgin Islands	United States Virgin Islands Department of Health John Moorehead Complex (Old Hospital) Communicable Diseases Clinic, Building I St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases	Local: 1.340.774.9000 Mon. – Fri. 8 a.m. – 5 p.m.
Utah	Utah Department of Health Utah Ryan White Part B Program P. O. Box 142104 Salt Lake City, UT 84114 https://epi.utah.gov/ryan-white/	Local: 1.801.538.6197 Mon. – Fri. 8 a.m. – 5 p.m.
Vermont	Vermont Department of Health Vermont Medication Assistance Program (VMAP) 280 State Drive Waterbury, VT 05671-8390 https://www.healthvermont.gov/disease-control/hiv/hiv-care	Local: 1.802.951.4005 Local: 1.802.863.7245 Mon. – Fri. 7:45 a.m. – 4:30 p.m.
Virginia	Virginia Department of Health HCS Unit, 2nd Floor, James Madison Building 109 Governor Street Richmond, VA 23219 http://www.vdh.virginia.gov/disease-prevention/eligibility/	Toll-free: 1.855.362.0658 Mon. – Fri. 8 a.m. – 5 p.m.
Washington	EIP Client Services P.O. Box 47841 Olympia, WA 98504-7841 https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program	Toll-free: 1.877.376.9316 (in-state only) Local: 1.360.236.3426 Mon. – Fri. 8 a.m. – 5 p.m. (except state holidays)

AIDS Drug Assistance Programs		
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State:	Agency Address \ Website:	Telephone \ Hours:
West Virginia	Jay Adams, HIV Care Coordinator PO Box 6360 Wheeling, WV 26003 https://oeeps.wv.gov/rwp/pages/default.aspx	Local: 1.304.232.6822 Mon. – Fri. 9 a.m. – 5 p.m.
Wisconsin	Department of Health Services Division of Public Health, Attn: ADAP P.O. Box 2659 Madison, WI 53701 https://www.dhs.wisconsin.gov/hiv/adap-consumer-client.htm	Toll-free: 1.800.991.5532 TTY: 1.800.947.3529 Mon. – Fri. 8 a.m. – 4:30 p.m.
Wyoming	Wyoming Department of Health Public Health Division Communicable Disease Treatment Program 122 West 25th Street, 3rd Floor West Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hiv/resources-for-patients/	Local: 1.307.777.6563 Mon. – Fri. 8 a.m. – 5 p.m.

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HealthSelect Medicare Rx PDP Customer Service

Method	Customer Service – Contact Information
Call	The phone number for HealthSelect Medicare Rx PDP is: (866) 264-4676 . Customer Service is available 24 hours a day, seven days a week. Customer Service also has free language interpreter services available for non-English speakers.
Write	Express Scripts Medicare P.O. Box 66535 St. Louis, MO 63166-6535
Website	HSMedicareRx.com

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