January 1 - December 31, 2024

EVIDENCE OF COVERAGE

Your Medicare Prescription Drug Coverage as a Member of Cigna Secure Rx (PDP)

This document gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-800-222-6700. (TTY users should call 711) Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1–September 30.

This plan, Cigna Secure Rx (PDP), is offered by Cigna Healthcare℠. (When this *Evidence of Coverage* says "we," "us," or "our," it means Cigna Healthcare. When it says "plan" or "our plan," it means Cigna Secure Rx (PDP).)

This document is available for free in Spanish.

This document is available in an alternate format such as braille or large print. Please contact Customer Service at 1-800-222-6700 (TTY 711) for additional information.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Cigna Secure Rx (PDP), which is a Medicare Prescription Drug Plan

You are covered by Original Medicare or another health plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, Cigna Secure Rx (PDP).

Cigna Secure Rx (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

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

This *Evidence of Coverage* document tells you how to get your prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan and how to file a complaint if you are 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 Cigna Secure Rx (PDP).

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

If you are confused, concerned or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in Cigna Secure Rx (PDP) between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Cigna Secure Rx (PDP) after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

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

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

Section 2.1 Your eligibility requirements

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

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B)
- — *and* — you are a United States citizen or are lawfully present in the United States
- — *and* — you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is the plan service area for Cigna Secure Rx (PDP)

Cigna Secure Rx (PDP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes all 50 states, the District of Columbia and Puerto Rico.

We offer coverage in all states and Puerto Rico. However, there may be cost or other differences between the plans we offer in each state. If you move out of state or territory and into a state territory that is still within our service area, you must call Customer Service in order to update your information.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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 Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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

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

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

Section 3.2 *Pharmacy Directory*

The pharmacy directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the Pharmacy Directory to find the network pharmacy you want to use. See Chapter 3, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have the *Pharmacy Directory,* you can get a copy from Customer Service. You can also find this information on our website at cigna.com/member-resources.

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Cigna Secure Rx (PDP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Cigna Secure Rx (PDP) "Drug List."

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

We will provide you a copy of the “Drug List”. The “Drug List” we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the “Drug List”, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan’s website (cigna.com/member-resources) or call Customer Service.

SECTION 4 Your monthly costs for Cigna Secure Rx (PDP)

Your costs may include the following:

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

In some situations, your plan premium could be less

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 sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service 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 *Medicare & You 2024* handbook, the section called “2024 Medicare Costs.” If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan Premium

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve.

State	2024 Monthly Premium	State	2024 Monthly Premium
Alabama	$56.80	Nebraska	$59.20
Alaska	$36.50	Nevada	$49.80
Arizona	$42.20	New Hampshire	$31.30
Arkansas	$36.40	New Jersey	$60.60
California	$34.50	New Mexico	$34.80
Colorado	$41.50	New York	$45.60
Connecticut	$54.30	North Carolina	$57.80
Delaware	$41.40	North Dakota	$59.20
Florida	$59.70	Ohio	$55.70
Georgia	$69.30	Oklahoma	$51.40
Hawaii	$78.60	Oregon	$39.90
Idaho	$57.40	Pennsylvania	$40.90
Illinois	$42.30	Puerto Rico	$64.00
Indiana	$52.60	Rhode Island	$54.30
Iowa	$59.20	South Carolina	$69.50
Kansas	$38.80	South Dakota	$59.20
Kentucky	$52.60	Tennessee	$56.80

Louisiana	$42.30	Texas	$44.00
Maine	$31.30	Utah	$57.40
Maryland	$41.40	Vermont	$54.30
Massachusetts	$54.30	Virginia	$62.40
Michigan	$33.90	Washington	$39.90
Minnesota	$59.20	Washington, D.C.	$41.40
Mississippi	$35.80	West Virginia	$40.90
Missouri	$57.80	Wisconsin	$48.00
Montana	$59.20	Wyoming	$59.20

Section 4.2 Monthly Medicare Part B Premium

Many 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. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty.** The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in Cigna Secure Rx (PDP), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $34.70, which equals $4.85. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

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

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining the plan, you may not have another chance to request a review of that late enrollment penalty.

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit 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 amount, 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 amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are 5 ways you can pay your plan premium.

Option 1: Paying by check

You will receive a monthly invoice from us approximately two weeks before the due date. Payments **MUST** be received by the 1st day of the coverage month. You must also pay your premium with a money order or cashier's check. You will not receive an invoice if you have a credit balance.

Please include your Customer ID number on your check. Checks should be made payable to "Cigna Healthcare-PDP" and mailed to:

Cigna Healthcare-PDP

P.O. Box 747102

Pittsburgh, PA 15274-7102

Checks should not be made out to the Centers for Medicare & Medicaid Services (CMS) or the U.S. Department of Health and Human Services (HHS) and should not be sent to these agencies.

If you and your spouse are both enrolled in a Cigna Healthcare Medicare Prescription Drug plan, you will receive separate invoices. Please include both invoice stubs along with your payment.

Option 2: You can request automatic payments from your bank account or credit card

You can elect to have your monthly premium automatically:

- Withdrawn from your bank account (checking or savings); or
- Charged to your credit card

Automatic payments take place on or about the 3rd day of each month.

If you are interested in signing up for automatic payments, please contact Customer Service for assistance.

Option 3: You can make payments online

You can pay your monthly plan premium by using Cigna Healthcare Medicare Prescription Drug Plans' secure online payment system, which allows you to set up automatic payments or make a one-time payment at your convenience. Our secure online payment system is available 24 hours a day, 7 days a week, and can be found online at www.cigna.com/PartDPremiumPayment.

We will process your payment within 48 hours.

Option 4: You can pay by phone

You can pay your monthly premium by calling Customer Service 24 hours a day, 7 days a week. A series of pre-recorded prompts will guide you through the process of paying over the phone, where you can set up automatic payments or make a one-time payment at your convenience. You can also call during business hours and a customer service representative will be happy to take your payment over the phone.

Option 5: Having your premium taken out of your monthly Social Security check

Changing the way you pay your plan premium. If you decide to change the option by which you pay your plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, call Customer Service at 1-800-222-6700 (TTY 711).

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the covered month. If we have not received your premium by the first day of the covered month, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within 2 months from the premium due date.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your plan premium

If we end your membership because you did not pay your premiums, you will still have health coverage under Original Medicare.

In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the amount you owe.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 7 of this document tells how to make a complaint, or you can call us at 1-800-222-6700 between 8 a.m. – 8 p.m., local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1–September 30. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Customer Service.

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

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Cigna Secure Rx (PDP) contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Cigna Secure Rx (PDP) Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-800-222-6700 Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.
FAX	1-800-735-1469
WRITE	Cigna Healthcare Medicare Prescription Drug Plans, P.O. Box 269005, Weston, FL 33326-9927
WEBSITE	cigna.com/member-resources

How to contact us when you are asking for a coverage decision or appeal

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

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-222-6700 Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.
FAX	1-866-845-7267
WRITE	Cigna Healthcare, Attn: Medicare Reviews, P.O. Box 66571, St. Louis, MO 63166-6571
WEBSITE	cigna.com/member-resources

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-800-222-6700 Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30..
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.
FAX	1-866-593-4482
WRITE	Cigna Healthcare, Attn: Part D Appeals, P.O. Box 66588, St. Louis, MO 63166-6588
WEBSITE	cigna.com/member-resources

How to contact us when you are making a complaint

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

Method	Complaints about Part D Prescription Drugs – Contact Information
CALL	1-800-222-6700 Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30..
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.
FAX	1-800-735-1469
WRITE	Cigna Healthcare, Attn: Member Grievances, P.O. Box 269005, Weston, FL 33326-9927
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. If you have received a bill or paid for drugs (such as a pharmacy bill) that you think we should pay for, you may need to ask the plan for reimbursement or to pay the pharmacy bill, see Chapter 5 *(Asking us to pay our share of the costs for covered drugs)*.

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

Method	Payment Requests – Contact Information
CALL	1-800-222-6700 Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.

Method	Payment Requests – Contact Information
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.
WRITE	Cigna Healthcare, Attn: Medicare Part D, P.O. Box 14718, Lexington, KY 40512-4718
WEBSITE	cigna.com/member-resources

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

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

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

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. See Appendix A in the back of this booklet to locate information for the SHIP in your state.

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

State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:
- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in the middle of page)
- Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

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

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. See Appendix B in the back of this booklet for a list of Quality Improvement Organizations.

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

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

SECTION 5 Social Security

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

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

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am ET to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

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

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

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

To find out more about Medicaid and its programs, contact the Medicaid agency for your state listed in Appendix C in the back of this booklet.

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

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

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

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this Chapter for contact information).

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

- If you are eligible for Medicaid and you believe our information about your Medicaid eligibility is incorrect, you may be able to submit evidence of your current Medicaid status. Please contact Customer Service to request assistance or to provide one of the documents listed below to establish your correct copay level. Please note that any document listed below must show that you were eligible for Medicaid during a month after June of the previous year:
  1. A copy of your Medicaid card which includes your name, eligibility date and status level;
  2. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status;
  3. A copy of a state document that confirms active Medicaid status;
  4. A printout from the state electronic enrollment file showing Medicaid status;
  5. A screen print from the state's Medicaid systems showing Medicaid status;
  6. Other documentation provided by the state showing Medicaid status;
  7. A Supplemental Security Income (SSI) Notice of Award with an effective date; or
  8. An Important Information letter from the Social Security Administration (SSA) confirming that you are "...automatically eligible for Extra Help..."
- If you are a member that is institutionalized, please provide one or more of the following:
  1. A remittance from a long-term care facility showing Medicaid payment for a full calendar month;
  2. A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar month on your behalf;
  3. A screen print from the state's Medicaid systems showing your institutional status based on at least a full calendar month's stay for Medicaid payment purposes.
  4. For Individuals receiving home and community based services (HCBS), you may submit a copy of:
     a) 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;
     b) 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;
     c) 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;
     d) Other documentation provided by the state showing HCBS eligibility status during a month after June of the previous calendar year; or,
     e) A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

  You can also visit the CMS website:

  https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/best_available_evidence_policy.html to find out more.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

What if you have 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. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

What is the AIDS Drug Assistance Program (ADAP)?

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

State Pharmaceutical Assistance Programs

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

See Appendix D in the back of this booklet for a list of State Pharmaceutical Assistance Programs.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive 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.

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

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:

Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

Section 1.1 What are "network providers" and "covered services"?

This Chapter **explains rules for using your coverage for Part D drugs**.

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2024* handbook.) Your Part D prescription drugs are covered under our plan.

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- 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 or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (cigna.com/member-resources), and/or call Customer Service.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Customer Service or use the *Pharmacy Directory*. You can also find information on our website at cigna.com/member-resources.

What if you need a specialized pharmacy?

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 any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Service.

Section 2.3 Using the plan's mail-order service

Our plan's mail-order service allows you to order **a 30-day, 60-day or 90-day supply.**

Pharmacies that offer preferred cost sharing are mail-order pharmacies in our network where the plan has negotiated lower cost sharing for members for covered drugs than at a standard cost sharing mail-order pharmacy. However, you will usually have lower drug prices at both preferred cost sharing and standard cost sharing mail-order pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

To get information about filling your prescriptions by mail please visit our website (cigna.com/member-resources) or contact Customer Service.

Usually a mail-order pharmacy order will be delivered to you in no more than 14 business days. You may be contacted by the mail-order services pharmacy and alternative dispensing arrangements will be made if your mail order is delayed.

New prescriptions the pharmacy receives directly from your doctor's office.

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

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by calling 1-877-860-0982 (TTY 711) or by logging in to myCigna.com.

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

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-877-860-0982 (TTY 711) or by logging in to myCigna.com.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto-refill program, but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 15 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 mail-order refills, please contact us by calling 1-877-860-0982 (TTY 711) or by logging in to myCigna.com.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

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

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost-sharing) at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case, you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You travel outside the plan's service area and run out of or lose covered Part D drugs, or become ill and need a covered Part D drug and cannot access a network pharmacy.
- You are unable to obtain a covered Part D drug in a timely manner within the service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24/7 service.
- You are filling a prescription for a covered Part D drug and that particular drug is not regularly stocked at an accessible network retail or mail order pharmacy.
- The Part D drugs are dispensed by an out-of-network institution-based pharmacy while in an emergency facility, provider-based clinic, outpatient surgery, or other outpatient setting.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

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

The plan has a *List of Covered Drugs (Formulary).* 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" are only those covered under Medicare Part D.

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

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

The "Drug List" includes brand name drugs and generic drugs

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to *drugs* this could mean a drug or a biological product.

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

What is *not* on the "Drug List"?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List". In some cases, you may be able to obtain a drug that is not on the "Drug List". For more information, please see Chapter 7.

Section 3.2 There are 5 cost-sharing tiers for drugs on the "Drug List"

Every drug on the plan's "Drug List" is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier the higher your cost for the drug.

- Cost-Sharing Tier 1: Preferred Generic Drugs. This tier includes preferred generic drugs. This grouping of prescription drugs represents the lowest cost sharing.
- Cost-Sharing Tier 2: Generic Drugs. This tier includes non-preferred generic drugs.
- Cost-Sharing Tier 3: Preferred Brand Drugs. This tier includes preferred brand drugs and may include non-preferred generic drugs.
- Cost-Sharing Tier 4: Non-Preferred Drugs. This tier includes non-preferred brand drugs and may include non-preferred generic drugs.
- Cost-Sharing Tier 5: Specialty Tier. This tier includes generic and brand name drugs that meet a certain criteria defined by Medicare. This grouping of prescription drugs represents the highest cost sharing.

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 your Part D prescription drugs*).

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

You have three ways to find out:

1. Check the most recent "Drug List" we sent you in the mail. (Please note: The "Drug List" we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List". If one of your drugs is not listed in the "Drug List", you should visit our website or contact Customer Service to find out if we cover it.)
2. Visit the plan's website (cigna.com/member-resources). The "Drug List" on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real Time Benefit Tool" (cigna.com/member-resources, then select "Find a Drug or Pharmacy"), or by calling Customer Service. With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List".

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

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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

Restricting brand name drugs when a generic version is available

Generally, a **generic** drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but 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 does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

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

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

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

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

If your drug is not on the "Drug List" or is restricted, here are options:

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

- **If you are a new member**, we will 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 will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

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

- **In order to accommodate unexpected transitions of members without time for advanced planning, such as level-of-care changes due to discharge from a hospital to a nursing facility or to a home, we will cover a temporary 30-day supply.**

For questions about a temporary supply, call Customer Service.

During the time when you are 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:

1. You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

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

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

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells 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 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

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. You can call Customer Service 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 request an exception to the rule.

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

Drugs in our Tier 5: Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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

Section 6.1 The "Drug List" can change during the year

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

- **Add or remove drugs from the "Drug List".**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**

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

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

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" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year.

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

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - o We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List", but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - o We may not tell you in advance before we make that change — even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
  - o You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7.
- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
  - o 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 are taking that drug, we will tell you right away.
  - o Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
  - o We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug 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.

- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7.

Changes to the "Drug List" that do not affect you during this plan year

We may make certain changes to the "Drug List" that are not described above. In these cases, the chances will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan. In general, changes that will not affect you during the current plan year are:

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other changes noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug. We will not tell you about these types of changes directly during the current plan year. You will need to check the "Drug List" for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. *Off-label use* is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

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 seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

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

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

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

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility?

If you are admitted to a hospital or to a skilled nursing facility, Original Medicare (or your Medicare health plan with Part A and B coverage, if applicable) will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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

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

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What 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?

Please refer to Section 5.2 about a temporary emergency supply.

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

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

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

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

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

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

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

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) 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 our plan.

In general, if you have employee or retiree group coverage. the 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 prescription 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.

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 the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g. anti-nausea drugs, laxatives, pain medication, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same 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 the ingredients you are allergic to.

- Possible errors in the amount (dosage) of a drug you are taking.
- Unsafe amounts of opioid pain medications.

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

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

We have a program that 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 doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

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

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active 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 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you quality 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 receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, 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 will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Service.

CHAPTER 4:

What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

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

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, Sections 1 through 4 explain these rules. When you use the plan's "Real Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling Customer Service.

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

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called *cost sharing*, and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does *not* 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 Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3):

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

It matters who pays:

- If you make these payments **yourself,** they are included in your out-of-pocket costs.
- These payments are *also included* 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, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

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

- We will help you. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 2.1 What are the drug payment stages for Cigna Secure Rx (PDP) members?

There are four **drug payment stages** for your prescription drug coverage under Cigna Secure Rx (PDP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

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

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

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

- We keep track of how much you have paid. This is called your **Out-of-Pocket" costs.**
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D Explanation of Benefits* (Part D EOB) The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called *year-to-date* information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **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 will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your Part D drugs

The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of $545 on Part D drugs. **You must pay the full cost of your Part D drugs** until you reach the plan's deductible amount. For all other drugs you will not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.

Once you have paid $545 for your Part D drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

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

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

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

The plan has 5 cost-sharing tiers

Every drug on the plan's "Drug List" is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1: Preferred Genetic Drugs. This tier includes preferred generic drugs. This grouping of prescription drugs represents the lowest cost sharing.
- Cost-Sharing Tier 2: Generic Drugs. This tier includes non-preferred generic drugs.
- Cost-Sharing Tier 3: Preferred Brand Drugs: This tier includes preferred brand drugs and may include non-preferred generic drugs.
- Cost-Sharing Tier 4: Non-Preferred Drugs. This tier includes non-preferred brand drugs and may include non-preferred generic drugs.
- Cost-Sharing Tier 5: Specialty Tier. This tier includes generic and brand name drugs that meet a certain criteria defined by Medicare. This grouping of prescription drugs represents the highest cost sharing.

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

Your pharmacy choices

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

- A network retail pharmacy that offers standard cost sharing.
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

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

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

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

As shown in the table below, the amount of the copayment or coinsurance depends on the cost sharing tier. Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
AK	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	41%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
AL, TN	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	46%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
AR	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
AZ	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
CA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$2.00	$0.00	$2.00	$2.00
	Cost-Sharing Tier 2 (Generic Drugs)	$7.00	$3.00	$7.00	$7.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	40%	40%	40%	40%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
CO	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	41%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
CT, MA, RI, VT	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	46%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
DE, DC, MD	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
FL	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	44%	43%	44%	44%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
GA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	46%	47%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
HI	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$9.00	$3.00	$9.00	$9.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
IA, MN, MT, ND, SD, NE, WY	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	47%	47%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
ID, UT	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	43%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
IL	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	48%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
IN, KY	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$9.00	$3.00	$9.00	$9.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	46%	47%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
KS	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	43%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
LA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$7.00	$3.00	$7.00	$7.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
MI	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$3.00	$0.00	$3.00	$3.00
	Cost-Sharing Tier 2 (Generic Drugs)	$7.00	$3.00	$7.00	$7.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
MO	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	47%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
MS	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	43%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
NC	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	47%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
NH, ME	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
NJ	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	45%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
NM	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
NV	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$9.00	$3.00	$9.00	$9.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	44%	43%	44%	44%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
NY	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$3.00	$0.00	$3.00	$3.00
	Cost-Sharing Tier 2 (Generic Drugs)	$7.00	$3.00	$7.00	$7.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
OH	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	44%	43%	44%	44%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
OK	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	46%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
OR, WA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	41%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
PA, WV	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$8.00	$3.00	$8.00	$8.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
PR	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	20%	19%	20%	20%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	50%	50%	50%	50%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
SC	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	46%	47%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
TX	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	48%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

States	Tier	**Standard retail cost sharing (in-network) and Standard Mail-order cost sharing** (up to a 30-day supply)	**Preferred retail cost sharing (in-network) and Preferred Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
VA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$4.00	$0.00	$4.00	$4.00
	Cost-Sharing Tier 2 (Generic Drugs)	$10.00	$3.00	$10.00	$10.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	48%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%
WI	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$2.00	$0.00	$2.00	$2.00
	Cost-Sharing Tier 2 (Generic Drugs)	$7.00	$2.00	$7.00	$7.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	40%	40%	40%	40%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	25%	25%	25%	25%

**You will pay the copay or coinsurance shown above plus the difference between the Out-of-Network pharmacy billed charge and our typical Standard Retail pharmacy billed costs.*

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

Typically, the amount you pay for a prescription drug covers a full month's supply. 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 are 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 of your drugs, if this will help you better plan refill dates for different prescriptions. If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the *daily cost-sharing rate*) and multiply it by the number of days of the drug you receive.

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

For some drugs, you can get a long-term supply (also called an *extended supply*). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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

States	Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard Mail-order cost sharing** (up to a 90-day supply)	**Preferred Mail-order cost sharing** (up to a 90-day supply)
AK	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	41%	42%	41%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
AL, TN	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	46%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
AR	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard Mail-order cost sharing** (up to a 90-day supply)	**Preferred Mail-order cost sharing** (up to a 90-day supply)
AZ	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
CA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$6.00	$0.00	$6.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$21.00	$9.00	$21.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	40%	40%	40%	40%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
CO	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	41%	42%	41%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
CT, MA, RI, VT	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	46%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Standard Mail-order cost sharing (up to a 90-day supply)	Preferred Mail-order cost sharing (up to a 90-day supply)
DE, DC, MD	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
FL	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	44%	43%	44%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
GA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	46%	47%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
HI	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$27.00	$9.00	$27.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard Mail-order cost sharing** (up to a 90-day supply)	**Preferred Mail-order cost sharing** (up to a 90-day supply)
IA, MN, MT, ND, SD, NE, WY	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	47%	47%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
ID, UT	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	43%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
IL	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	48%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
IN, KY	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$27.00	$9.00	$27.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	46%	47%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Standard Mail-order cost sharing (up to a 90-day supply)	Preferred Mail-order cost sharing (up to a 90-day supply)
KS	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	43%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
LA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$21.00	$9.00	$21.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
MI	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$9.00	$0.00	$9.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$21.00	$9.00	$21.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
MO	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	47%	48%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard Mail-order cost sharing** (up to a 90-day supply)	**Preferred Mail-order cost sharing** (up to a 90-day supply)
MS	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	43%	43%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
NC	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	47%	48%	47%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
NH, ME	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
NJ	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	45%	46%	45%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard Mail-order cost sharing** (up to a 90-day supply)	**Preferred Mail-order cost sharing** (up to a 90-day supply)
NM	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	42%	42%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
NV	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$27.00	$9.00	$27.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	44%	43%	44%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
NY	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$9.00	$0.00	$9.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$21.00	$9.00	$21.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
OH	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	44%	43%	44%	43%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Standard Mail-order cost sharing (up to a 90-day supply)	Preferred Mail-order cost sharing (up to a 90-day supply)
OK	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	46%	46%	46%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
OR, WA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	42%	41%	42%	41%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
PA, WV	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$24.00	$9.00	$24.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	43%	42%	43%	42%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
PR	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	20%	19%	20%	19%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	50%	50%	50%	50%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

States	Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Standard Mail-order cost sharing (up to a 90-day supply)	Preferred Mail-order cost sharing (up to a 90-day supply)
SC	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	47%	46%	47%	46%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
TX	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	16%	17%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	48%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
VA	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$12.00	$0.00	$12.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$30.00	$9.00	$30.00	$3.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	17%	17%	17%	17%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	48%	48%	48%	48%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			
WI	**Cost-Sharing Tier 1** (Preferred Generic Drugs)	$6.00	$0.00	$6.00	$0.00
	Cost-Sharing Tier 2 (Generic Drugs)	$21.00	$6.00	$21.00	$2.00
	Cost-Sharing Tier 3 (Preferred Brand Drugs)	16%	16%	16%	16%
	Cost-Sharing Tier 4 (Non-Preferred Drugs)	40%	40%	40%	40%
	Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.			

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage.**

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this $5,030 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay, and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount, $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. Please see Section 8 of this chapter for more information on Part D vaccines and cost-sharing for Part D vaccines.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's "Drug List" or contact Customer Service for coverage and cost-sharing details about specific vaccines.

Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

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**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depends on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**

- A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

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

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

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

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost, by using the procedures that are described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance or copayment for the vaccines, including administration.

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment or coinsurance for the vaccines administration, less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

CHAPTER 5:

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

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

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called *reimbursing* you). There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

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

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

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances.

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

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

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

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

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

   - For example, the drug may not be on the plan's "Drug List" or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. **If you are retroactively enrolled in our plan**

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

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

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

SECTION 2 How to ask us to pay you back

You may request 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.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (cigna.com/member-resources (Customer Forms) or call Customer Service and ask for the form.

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

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

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

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

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

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

The 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 Our plan must honor your rights and cultural sensitivities as a member of the 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, in braille, in large print, or other alternate formats, etc.) Debemos proporcionarle la información de manera que la entienda bien y que sea consistente con sus sensibilidades culturales (en idiomas que no sean inglés, en braille, en letra grande o en otros formatos alternativos, etc.)

You 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 a plan may meet these accessibility requirements include, but are not limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Member Grievances department (phone numbers are printed in the Complaints About Part D Prescription Drugs contact information in Chapter 2, Section 1 of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Su plan tiene la obligación de asegurarse de que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera culturalmente competente y sean accesibles a todos los afiliados, incluidos los que tienen dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o personas con antecedentes culturales y étnicos diversos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la provisión de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder preguntas de los miembros que no hablan inglés. También podemos darle de manera gratuita información en braille, en letra grande o en otros formatos alternativos si lo necesita. Tenemos la obligación de darle la información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para que le proporcionemos información de manera que la entienda bien, llame a Servicio al Cliente.

Si tiene algún problema para recibir la información de nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar un reclamo a través de nuestro departamento de Reclamos de los Miembros (los números de teléfono están impresos en la información de contacto de Quejas respecto del cuidado médico en la Sección 1 del Capítulo 2 de este folleto). También puede presentar una queja ante Medicare llamando al 1 800 MEDICARE (1 800 633 4227) o directamente a la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

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

You have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

- Your *personal health information* includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- 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 Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- 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 do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your 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 are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

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

As a member of Cigna Secure 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.

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network pharmacies.** You have the right to get information from us about 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 prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with a state-specific agency such as a State Health Insurance Assistance Program (SHIP) or Quality Improvement Organization (QIO). Please refer to Appendix A and Appendix B in the back of this booklet to find contact information for the State Health Insurance Assistance Program (SHIP) or Quality Improvement Organization (QIO) in your state.

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

If you have any problems, concerns or complaints and need to request 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 are required to treat you fairly**

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

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

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

Is it about something else?

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048_.

Section 1.8 How to get more information about your rights

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.);
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **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 is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
  - **If you move *within* our 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* our plan service area**, you cannot remain a member of our plan.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

SECTION 1 Introduction

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

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

- For some 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the 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 and can be hard to understand.

To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than organization determination and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible

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

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in Appendix A of this document.

Medicare

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

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

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

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.

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, 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 prior to receiving benefits

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

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

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

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request 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 were following the rules. When we have completed 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 will 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. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 5 of this of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal. (Section 6 in this chapter explains the Level 3, 4 and 5 appeals processes).

Section 4.2 How to get help when you are 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:

- You **can call us at Customer Service.**
- 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 prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will 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 may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

Section 5.1 This section tells what to do if you have problems getting a Part D drug or if you 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. (See Chapter 3, for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time.
- We also use the term "Drug List" instead of *List of Covered Drugs* or *Formulary*
- If you 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 will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs.* **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) **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 have already bought. **Ask us to pay you back. Section 5.4**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

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 is not covered in the way you would like it to be covered, you can ask us to make an *exception*. An exception is a type of coverage decision.

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

1. **Covering a part D drug for you that is not on our “Drug List”.** If we agree to cover a drug not on the “Drug List”, you will need to pay the cost-sharing amount that applies to drugs in Tier 4: Non-Preferred Drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our “Drug List”. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our “Drug List” contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- 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 that contains biological product alternatives for treating your condition.
- If the drug you’re taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you’re taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5: Specialty Tier.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision

Standard coverage decision are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

***If your health requires it, as 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 have not yet received*. (You cannot 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 will 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 will decide whether your health requires that we give you a fast coverage decision**. If we do not approve a fast coverage decision, we will 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 will 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 requested. We will answer your complaint within 24 hours of receipt.

<u>Step 2:</u> Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for 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, or on our plan's form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying 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 are requesting 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.

<u>Step 3:</u> 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 receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will

give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

<u>Step 4:</u> **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 Step-by-step: How to make a Level 1 Appeal

Legal Term
An appeal to the plan about a medical care coverage decision is called a plan **redetermination.**
A "fast appeal" is also called an **expedited redetermination.**

<u>Step 1:</u> **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 are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a *fast appeal.*
- The requirements for getting a *fast appeal* are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

<u>Step 2:</u> **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 1-800-222-6700 (TTY 711)**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- Coverage requests involving prescription drugs can also be submitted electronically on our website at www.cigna.com/medicare/resources/customer-forms
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting 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. We are allowed to charge a fee for copying and sending this information to you.

<u>Step 3:</u> **We consider your appeal and we give you our answer.**

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

<u>Step 4:</u> **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 a 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 is not connected with us and it 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.
- If, however, 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 will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your case file. **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization does a review of your appeal and gives you an answer.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

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

Deadlines for *standard appeal*

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug, you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The Independent review organization gives you an answer

For fast appeals:

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

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 review organization **within 72 hours** after we receive the decision from the 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 are required to** send payment to you within 30 calendar days **after we receive the decision from the review organization.**

What if the review organization says no to your appeal?

If this organization says no to part of 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 is also called *turning down your appeal*.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.

- Telling 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 on 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 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

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

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

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

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

Level 3 appeal **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 receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, 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 the 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 Customer Service? Do you feel you are being encouraged to leave the plan?
Waiting times	Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at the plan? o 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 related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples. You have asked for a *fast coverage decision* or a *fast appeal,* and we have said no; you can make a complaint. You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. You believe we are not 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.**

Section 7.3 Step-by-step: Making a complaint

<u>Step 1:</u> **Contact us promptly — either by phone or in writing.**

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You may submit your written complaints by mail or facsimile to:

  Cigna
  Attn: Member Grievances
  P.O. Box 269005
  Weston, FL 33326-9927
  Fax: 1-800-735-1469

  For standard grievances received in writing, we will respond to you in writing within 30 calendar days of receipt of your written complaint. For expedited grievances, we must decide and notify you within 24 hours.
- The deadline for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

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

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

When your complaint is about *quality of care*, you also 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 health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Cigna Secure Rx (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your prescription drugs and you will continue to pay your cost share until your membership ends.

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

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

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the *Annual Open Enrollment Period*). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from October 15 to December 7.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans.
  - Another Medicare prescription drug plan.
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.

    If you enroll in most Medicare health plans, you will be disenrolled from Cigna Secure Rx (PDP) when your new plan's coverage begins. However, if you choose a Private Free-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep Cigna Secure Rx (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

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

In certain situations, members of Cigna Secure Rx (PDP) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples; for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - If you have moved out of your plan's service area.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

- Note: If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period,** please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.

  Note: if you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare health plans, you will automatically be disenrolled from Cigna Secure Rx (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep Cigna Secure Rx (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.
- **Your membership will usually end** on the first day of the month after we receive your request to change your plan.

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

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

- **Call Customer Service.**
- You can find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

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

If you would like to switch from our plan to:	This is what you should do:
Another Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan between October 15 and December 7. You will automatically be disenrolled from Cigna Secure Rx (PDP) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
- A Medicare health plan.	- Enroll in the new Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from Cigna Secure Rx (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep Cigna Secure Rx (PDP) for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Customer Service if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).
- Original Medicare *without* a separate Medicare prescription drug plan.	- **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this. - You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

Until your membership ends and your new Medicare coverage goes begins, you must continue to get your prescription drugs through our plan.

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

SECTION 5 Cigna Secure Rx (PDP) must end your membership in the plan in certain situations

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

Cigna Secure Rx (PDP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay past due plan premiums within 2 months from entering the plans failure to pay grace period. If you are receiving "Extra Help" with your premium from Medicare (Low Income Subsidy), this amount is 5X your monthly plan

premium responsibility. If you are NOT receiving “Extra Help” with your premium from Medicare, this amount is 2X your monthly premium responsibility.

- We must notify you in writing that you have 2 months from the premium due date to pay the plan premium before we end your membership.

- 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 our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

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

Cigna Secure Rx (PDP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

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, or 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 are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Customer Service. 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, Cigna Secure Rx (PDP), 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 Notice about subrogation and third party recovery

If we make any payment to you or on your behalf for Covered Services, we are permitted to be fully subrogated (a legal principle that allows the plan to be reimbursed for certain payments we have made on your behalf, in certain circumstances) to any and all rights you have against any person, entity or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness or condition. We are given the same rights of subrogation and recovery that are available to the Medicare Program under the Medicare Secondary Payer rules. We may use whatever rights of recovery are available to the Medicare program under 42 U.S.C. § 1395mm(e)(4), 42 U.S.C. §1395w-22(a)(4), 42 C.F.R. Part 411, and 42 C.F.R. Part 422.

Once we have made a payment for Covered Services, we will have a lien on the proceeds of any judgment, settlement, or other award or recovery you may receive or be entitled to receive, including but not limited to the following:

1. Any award, settlement, benefits or other amounts paid under any workers' compensation law or award;
2. Any and all payments made directly by or on behalf of a third party tortfeasor or person, entity or insurer responsible for indemnifying the third party tortfeasor;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

You agree to cooperate with us and any of our designated representatives and to take any actions or steps necessary to secure our lien/interests, including but not limited to:

1. Fully responding to requests for information about any accidents or injuries;
2. Fully responding to our requests for information and providing any relevant information that we have requested; and
3. Fully participating in all phases of any legal action we may need to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to affect our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior authorized written consent. Your failure to cooperate shall be deemed a violation or breach of your obligations, and we may seek any available legal action against you to protect our rights.

We are also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under the Plan. You must immediately pay to us any amounts you get by judgment, settlement, award, recovery or otherwise from any third party or his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in this Plan.

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, impacted or eliminated by the “made whole” doctrine or any other doctrine that may apply.

We are not required to pursue subrogation or reimbursement either for our benefit or on your behalf. Our rights under this *Evidence of Coverage* shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you seek relating to your injury, illness, or condition.

If you disagree with any decision or action we take in connection with the subrogation and third party recovery provisions outlined above, you must follow the procedures explained in Chapter 7 of this booklet: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

SECTION 5 Report Fraud, Waste and Abuse

Health care fraud is a violation of federal and/or state law. If you know of or suspect health insurance fraud, please report it by calling our Compliance and Ethics Hotline at 1-800-472-8348. You are not required to identify yourself when you report the information. The hotline is anonymous.

CHAPTER 10:

Definitions of important words

Chapter 10. Definitions of important words

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.

Annual Enrollment Period – The set 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.

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 cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product.

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 $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time period 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.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed *copayment* amount that a plan requires when a specific drug is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

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

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

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily Cost-Sharing Rate – A *daily cost sharing* rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $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 our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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 are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of 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 our 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 request an exception if our plan sponsor requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

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

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

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

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

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. 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.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

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

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not 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.

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

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our 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.

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

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

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

Part C – see 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 as Part D drugs by Congress.

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

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

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

Prior Authorization – Approval in advance to get certain drugs. Covered drugs that need prior authorization are marked in the formulary.

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

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

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

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.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

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

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

Appendix A: State Health Insurance Assistance Programs (SHIP) contact information

Alabama

Alabama State Health Insurance Assistance Program

CALL	1-800-243-5463
WRITE	Alabama State Health Insurance Assistance Program, Alabama Department of Senior Services, RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104
WEBSITE	https://alabamaageline.gov/ship/

Alaska

State Health Insurance Assistance Program

CALL	1-907-269-3680 or 1-800-478-6065
TTY	1-800-770-8973
WRITE	State Health Insurance Assistance Program, Alaska Dept. of Health, Division of Senior & Disabilities Services, 240 Main Street, Suite 601, Juneau, AK 99801
WEBSITE	https://health.alaska.gov/dsds/Pages/medicare/default.aspx

Arizona

State Health Insurance Assistance Program

CALL	1-800-432-4040
TTY	711.0
WRITE	State Health Insurance Assistance Program, Department of Economic Security, Division of Aging and Adult Services (DAAS), 1789 W. Jefferson Street, #6272, Phoenix, AZ 85007
WEBSITE	https://des.az.gov/medicare-assistance

Arkansas

Senior Health Insurance Information Program (SHIIP)

CALL	1-501-371-2782 or 1-800-224-6330
WRITE	Senior Health Insurance Information Program (SHIIP), Arkansas Insurance Department, 1 Commerce Way, Little Rock, AR 72201
WEBSITE	https://insurance.arkansas.gov/consumer-services/senior-health/

California

Health Insurance Counseling & Advocacy Program (HICAP)

CALL	1-916-465-8104 or 1-800-434-0222
TTY	1-800-735-2929
WRITE	California Health Advocates, 5380 Elvas Avenue, Suite 221, Sacramento, CA 95819
WEBSITE	https://cahealthadvocates.org/hicap/

Colorado

Senior Health Insurance Assistance Program

CALL	1-303-894-7499 or 1-888-696-7213
TTY	1-303-894-7880
WRITE	Senior Health Insurance Assistance Program, Department of Regulatory Agencies, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202
WEBSITE	https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare

Connecticut

CHOICES

CALL	1-860-424-5055 or 1-800-994-9422
TTY	1-860-247-0775
WRITE	Department of Aging and Disability Services, Central Office, 55 Farmington Avenue, 12th Floor, Hartford, CT 06105
WEBSITE	https://portal.ct.gov/ADS-CHOICES

Delaware

Delaware Medicare Assistance Bureau (DMAB)

CALL	1-302-674-7364 or 1-800-336-9500
WRITE	Delaware Medicare Assistance Bureau (DMAB), 1901 N. Dupont Highway, New Castle, DE 19720
WEBSITE	http://insurance.delaware.gov/divisions/dmab/

District of Columbia

Health Insurance Counseling Project (HICP)

CALL	1-202-727-8370
TTY	711.0
WRITE	State Health Insurance Assistance Program (SHIP), 250 E Street SW, Washington, DC 20024
WEBSITE	https://dacl.dc.gov/service/health-insurance-counseling

Florida

SHINE (Serving Health Insurance Needs of Elders)

CALL	1-800-963-5337
TTY	1-800-955-8770
WRITE	SHINE, Department of Elder Affairs, 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000
WEBSITE	www.floridashine.org

Georgia

Georgia SHIP

CALL	1-404-657-5258 or 1-866-552-4464 (Option 4)
TTY	1-404-657-1929
WRITE	Georgia SHIP, 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303
WEBSITE	https://aging.georgia.gov/georgia-ship

Hawaii

Hawaii SHIP

CALL	1-808-586-7299 or 1-888-875-9229
TTY	1-866-810-4379
WRITE	Hawaii SHIP, Executive Office on Aging, Hawaii State Department of Health, No. 1 Capitol District, 250 S. Hotel Street, Suite 406, Honolulu, HI 96813-2831
WEBSITE	www.hawaiiship.org/

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)

CALL	1-800-247-4422
WRITE	Senior Health Insurance Benefits Advisors (SHIBA), Idaho Department of Insurance, 700 W. State Street, 3rd Floor, P.O. Box 83720, Boise, ID 83720-0043
WEBSITE	https://doi.idaho.gov/SHIBA/

Illinois

Senior Health Insurance Program (SHIP)

CALL	1-800-252-8966
TTY	711.0
WRITE	Senior Health Insurance Program (SHIP), Illinois Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702
WEBSITE	https://ilaging.illinois.gov/ship.html

Indiana

State Health Insurance Assistance Program (SHIP)

CALL	1-800-452-4800
TTY	1-866-846-0139
WRITE	State Health Insurance Assistance Program (SHIP), Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, IN 42604-2787
WEBSITE	https://www.in.gov/ship/

Iowa

Senior Health Insurance Information Program (SHIIP)

CALL	1-800-351-4664
TTY	1-800-735-2942
WRITE	SHIIP-SMP, Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, IA 50315
WEBSITE	https://shiip.iowa.gov/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)

CALL	1-800-860-5260
TTY	1-785-291-3167
WRITE	Senior Health Insurance Counseling for Kansas (SHICK), Kansas Department for Aging and Disability Services, New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
WEBSITE	https://kdads.ks.gov/kdads-commissions/long-term-services-supports/aging-services/medicare-programs/shick

Kentucky

State Health Insurance Assistance Program

CALL	1-502-564-6930 or 1-877-293-7447 (option 2)
TTY	1-800-648-6056
WRITE	State Health Insurance Assistance Program, Cabinet for Health and Family Services, Department for Aging and Independent Living (DAIL), 275 E. Main Street, Frankfort, KY 40621
WEBSITE	https://www.chfs.ky.gov/agencies/dail/Pages/ship.aspx

Louisiana

Senior Health Insurance Information Program (SHIIP)

CALL	1-225-342-5301 or 1-800-259-5300
WRITE	Senior Health Insurance Information Program (SHIIP), Louisiana Department of Insurance, P.O. Box 94214, Baton Rouge, LA 70804
WEBSITE	https://www.ldi.la.gov/consumers/senior-health-shiip

Maine

Maine State Health Insurance Program (SHIP)

CALL	1-207-287-3707
TTY	711 or 1-800-606-0215
WRITE	Maine State Health Insurance Program (SHIP), Department of Health and Human Services, 109 Capitol Street, Augusta, ME 04333
WEBSITE	https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance

Maryland

Senior Health Insurance Assistance Program

CALL	1-410-767-1100 or 1-800-243-3425
TTY	711.0
WRITE	Senior Health Insurance Assistance Program, Maryland Department of Aging, 301 W. Preston Street, Suite 1007, Baltimore, MD 21201
WEBSITE	https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Massachusetts

Serving the Health Insurance Needs of Everyone (SHINE)

CALL	1-800-243-4636
TTY	1-800-439-2370
WRITE	Serving the Health Insurance Needs of Everyone (SHINE), 300 Hillside Avenue, Needham, MA 02494
WEBSITE	https://www.mass.gov/health-insurance-counseling

Michigan

Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.)

CALL	1-800-803-7174
WRITE	Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.), 6105 W. Joe Highway, Suite 204, Lansing, MI 48917
WEBSITE	www.mmapinc.org/

Minnesota

Minnesota State Health Insurance Assistance

CALL	1-800-333-2433
TTY	1-800-627-3529
WRITE	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line, Minnesota Board on Aging, 540 Cedar Street, St. Paul, MN 55164
WEBSITE	https://mn.gov/senior-linkage-line/older-adults/medicare/

Mississippi

State Health Insurance Assistance Program (SHIP)

CALL	1-601-359-4500 or 1-800-948-3020
WRITE	State Health Insurance Assistance Program (SHIP), Mississippi Department of Human Services, Division of Aging & Adult Services, 200 S. Lamar Street, Jackson, MS 39201
WEBSITE	http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

Missouri

CLAIM - State Health Insurance Assistance Program

CALL	1-800-390-3330
WRITE	CLAIM - State Health Insurance Assistance Program, 1105 Lakeview Avenue, Columbia, MO 65201
WEBSITE	www.missouriclaim.org

Montana

Montana State Health Insurance Assistance Program (SHIP)

CALL	1-406-444-4077 or 1-800-551-3191
WRITE	Montana State Health Insurance Assistance Program (SHIP), Department of Public Health & Human Services, Senior and Long Term Care Division, 1100 N. Last Chance Gulch, 4th Floor, Helena, MT 59601
WEBSITE	https://dphhs.mt.gov/sltc/aging/ship

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)

CALL	1-402-471-2201 or 1-800-234-7119
TTY	1-800-833-7352
WRITE	Nebraska Senior Health Insurance Information Program (SHIIP), Nebraska Department of Insurance, P.O. Box 95087, Lincoln, NE 68509-5087
WEBSITE	https://doi.nebraska.gov/consumer/senior-health

Nevada

State Health Insurance Assistance Program

CALL	1-775-687-4210 or 1-800-307-4444
WRITE	State Health Insurance Assistance Program, Nevada Aging and Disability Services Division, 3416 Goni Road, Suite D-132, Carson City, NV 89706
WEBSITE	http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/

New Hampshire

ServiceLink Aging & Disability Resource Center

CALL	1-866-634-9412
TTY	1-800-735-2964
WRITE	ServiceLink Aging & Disability Resource Center, Bureau of Elderly & Adult Services, Division of Community Based Care Services, NH Department of Health & Human Services, 129 Pleasant Street, Concord, NH 03301
WEBSITE	https://www.servicelink.nh.gov//

New Jersey

State Health Insurance Assistance Program (SHIP)

CALL	1-800-792-8820
WRITE	State Health Insurance Assistance Program (SHIP), Division of Aging Services, P.O. Box 715, Trenton, NJ 08625-0715
WEBSITE	www.state.nj.us/humanservices/doas/services/ship/index.html

New Mexico

Aging & Disability Resource Center (ADRC)

CALL	1-800-432-2080
TTY	1-505-476-4937
WRITE	Aging & Disability Resource Center (ADRC), New Mexico Aging & Long-Term Services Department, 2550 Cerrillos Road, Santa Fe, NM 87505
WEBSITE	https://aging.nm.gov/

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)

CALL 1-800-701-0501
WRITE Health Insurance Information Counseling and Assistance Program (HIICAP), New York State Office for the Aging, 2 Empire State Plaza, 5th Floor, Albany, NY 12223-1251
WEBSITE https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

North Carolina

Seniors' Health Insurance Information Program (SHIIP)

CALL 1-855-408-1212
WRITE Seniors' Health Insurance Information Program (SHIIP), NC Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201
WEBSITE https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip

North Dakota

State Health Insurance Counseling Program (SHIC)

CALL 1-701-328-2440 or 1-888-575-6611
TTY 1-800-366-6888
WRITE State Health Insurance Counseling Program (SHIC), North Dakota Insurance Department, 600 East Boulevard Avenue, Bismarck, ND 58505-0320
WEBSITE https://www.insurance.nd.gov/consumers/medicare-assistance

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)

CALL 1-800-686-1578
TTY 1-614-644-3745
WRITE Ohio Senior Health Insurance Information Program (OSHIIP), The Ohio Department of Insurance, 50 W. Town Street, 3rd Floor, Suite 300, Columbus, OH 43215
WEBSITE https://insurance.ohio.gov/consumers/medicare/medicare-counseling-webinars#MedicareVirtualOnlineCounseling

Oklahoma

Senior Health Insurance Counseling Program (SHIP)

CALL 1-405-521-2828 or 1-800-763-2828
WRITE Senior Health Insurance Counseling Program (SHIP), Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City , OK 73105
WEBSITE http://www.okdrs.org/guide/senior-health-insurance-counseling-program-ship

Oregon

Senior Health Insurance Benefits Assistance Program (SHIBA)

CALL 1-800-722-4134
TTY 1-800-735-2900
WRITE Senior Health Insurance Benefits Assistance Program (SHIBA), 500 Summer Street NE E-12, Salem, OR 97301
WEBSITE https://shiba.oregon.gov/Pages/index.aspx?utm_source=shiba&utm_medium=egov_redirect&utm_campaign=https%3A%2F%2Fhealthcare.oregon.gov%2Fshiba%2F

Pennsylvania

Pennsylvania Medicare Education and Decision Insight (PA MEDI)

CALL 1-800-783-7067
WRITE Pennsylvania Medicare Education and Decision Insight (PA MEDI), Pennsylvania Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919
WEBSITE https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

Puerto Rico

Office for the Elderly

CALL 1-787-721-6121
WRITE Oficina del Procurador de las Personas de edad avanzada, P.O. Box 191179, San Juan, PR 00919-1179
WEBSITE https://agencias.pr.gov/agencias/oppea/Pages/default.aspx

Rhode Island

Senior Health Insurance Program (SHIP)

CALL	1-401-462-3000 or 1-888-884-8721
TTY	1-401-462-0740
WRITE	Senior Health Insurance Program (SHIP), Rhode Island Office of Healthy Aging, 25 Howard Avenue, Building 57, Cranston, RI 02920
WEBSITE	https://oha.ri.gov/Medicare

South Carolina

State Health Insurance Assistance Program (SHIP)

CALL	1-803-734-9900 or 1-800-868-9095
WRITE	State Health Insurance Assistance Program, South Carolina Department on Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201
WEBSITE	https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud

South Dakota

Senior Health Information & Insurance Education (SHIINE)

CALL	1-800-536-8197
WRITE	Senior Health Information & Insurance Education (SHIINE), South Dakota Department of Human Services Division of Long Term Services and Support, 500 E. Capitol Avenue, Pierre, SD 57501
WEBSITE	www.shiine.net/

Tennessee

Tennessee State Health Insurance Assistance Program (SHIP)

CALL	1-877-801-0044
WRITE	Tennessee State Health Insurance Assistance Program (SHIP), Tennessee Commission on Aging and Disability, 502 Deaderick Street, 9th Floor, Nashville, TN 37243-0860
WEBSITE	https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html

Texas

Texas Health Information Counseling & Advocacy Program (HICAP)

CALL	1-800-252-9240
TTY	711.0
WRITE	Texas Health Information Counseling & Advocacy Program (HICAP), Texas Health and Human Services, P.O. Box 13247, Austin, TX 78711-3247
WEBSITE	https://hhs.texas.gov/services/health/medicare

Utah

State Health Insurance Assistance Program (SHIP)

CALL	1-800-541-7735
WRITE	State Health Insurance Assistance Program (SHIP), Utah Department of Health & Human Services, Division of Aging and Adult Services, Multi-Agency State Office Building, 195 North 1950 West, Salt Lake City, UT 84116
WEBSITE	https://daas.utah.gov/seniors/#shiip

Vermont

Vermont State Health Insurance Assistance Program (SHIP)

CALL	1-800-642-5119
WRITE	Vermont Association for Area Agencies on Aging, Vermont State Health Insurance Assistance Program (SHIP), 27 Main Street, Suite 14, Montpelier, VT 05602
WEBSITE	https://www.vermont4a.org/medicare-information

Virginia

Virginia Insurance Counseling & Assistance Program (VICAP)

CALL	1-804-662-9333 or 1-800-552-3402
TTY	1-804-662-9333 or 1-800-552-3402
WRITE	Virginia Insurance Counseling & Assistance Program (VICAP), Office for Aging Services, Division for Community Living, 1610 Forest Avenue, Suite 100, Henrico, VA 23229
WEBSITE	https://www.vda.virginia.gov/vicap.htm

Washington

Statewide Health Insurance Benefits Advisors (SHIBA)

CALL	1-800-562-6900
TTY	1-360-586-0241
WRITE	Statewide Health Insurance Benefits Advisors (SHIBA), Office of the Insurance Commissioner, P.O. Box 40255, Olympia, WA 98504-0255
WEBSITE	https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba

West Virginia

West Virginia SHIP

CALL	1-304-558-3317 or 1-877-987-4463
WRITE	West Virginia SHIP, 1900 Kanawha Boulevard East, Charleston, WV 25305
WEBSITE	www.wvship.org/

Wisconsin

State Health Insurance Assistance Program (SHIP)

CALL	1-800-242-1060
TTY	711 or 1-800-947-3529
WRITE	State Health Insurance Assistance Program (SHIP), Wisconsin Department of Health Services, 1 West Wilson Street, Madison, WI 53703
WEBSITE	https://dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)

CALL	1-800-856-4398
WRITE	Wyoming State Health Insurance Information Program (WSHIIP), 106 West Adams Avenue, Riverton, WY 82501
WEBSITE	www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

Appendix B: Quality Improvement Organizations (QIO) contact information

Alabama

KEPRO
CALL 1-888-317-0751
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE www.keproqio.com

Alaska

KEPRO
CALL 1-888-305-6759
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE www.keproqio.com

Arizona

Livanta
CALL 1-877-588-1123
TTY 1-855-887-6668
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

Arkansas

KEPRO
CALL 1-888-315-0636
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE www.keproqio.com

California

Livanta
CALL 1-877-588-1123
TTY 1-855-887-6668
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

Colorado

KEPRO
CALL 1-888-317-0891
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE www.keproqio.com

Connecticut

KEPRO
CALL 1-888-319-8452
TTY 1-855-843-4776
HOURS Hours are Mon.-- Fri. 9:00 a.m. -- 5:00 p.m., weekends and holidays: 11:00 a.m. -- 3:00 p.m.
WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE www.keproqio.com

Delaware

Livanta
CALL 1-888-396-4646
TTY 1-888-985-2660
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

District of Columbia

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Florida

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Georgia

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Hawaii

Livanta

CALL	1-877-588-1123
TTY	1-855-887-6668
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Idaho

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Illinois

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Indiana

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Iowa

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Kansas

Livanta
CALL 1-888-755-5580
TTY 1-888-985-9295
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

Kentucky

KEPRO
CALL 1-888-317-0751
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE www.keproqio.com

Louisiana

KEPRO
CALL 1-888-315-0636
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE www.keproqio.com

Maine

KEPRO
CALL 1-888-319-8452
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE www.keproqio.com

Maryland

Livanta
CALL 1-888-396-4646
TTY 1-888-985-2660
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

Massachusetts

KEPRO
CALL 1-888-319-8452
TTY 1-855-843-4776
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE www.keproqio.com

Michigan

Livanta
CALL 1-888-524-9900
TTY 1-888-985-8775
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

Minnesota

Livanta
CALL 1-888-524-9900
TTY 1-888-985-8775
HOURS Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE www.livantaqio.com

Mississippi

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Missouri

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Montana

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Nebraska

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Nevada

Livanta

CALL	1-877-588-1123
TTY	1-855-887-6668
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

New Hampshire

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

New Jersey

Livanta

CALL	1-866-815-5440
TTY	1-866-868-2289
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

New Mexico

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

New York

Livanta

CALL	1-866-815-5440
TTY	1-866-868-2289
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

North Carolina

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

North Dakota

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Ohio

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Oklahoma

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Oregon

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Pennsylvania

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Rhode Island

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

South Carolina

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

South Dakota

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Tennessee

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Texas

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Utah

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Vermont

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Virginia

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Washington

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

West Virginia

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Wisconsin

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Wyoming

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Appendix C: State Medicaid Agencies contact information

Alabama

Alabama Medicaid Agency

CALL	1-334-242-5000 or 1-800-362-1504
TTY	1-800-253-0799
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Alabama Medicaid Agency, P.O. Box 5624, Montgomery, AL 36103-5624
WEBSITE	www.medicaid.alabama.gov

Alaska

State of Alaska Department of Health & Social Services

CALL	1-800-478-7778 or 1-800-780-9972
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	State of Alaska Department of Health & Social Services, Division of Health Care Services, 4601 Business Park Boulevard, Suite 24, Bldg. K, Anchorage, AK 99503-7167
WEBSITE	https://health.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx

Arizona

Arizona Health Care Cost Containment System (AHCCCS)

CALL	1-602-417-4000 or 1-800-654-8713
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Arizona Health Care Cost Containment System (AHCCCS), 801 E. Jefferson Street, Phoenix, AZ 85034
WEBSITE	https://www.azahcccs.gov

Arkansas

Arkansas Medicaid

CALL	1-855-372-1084
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Arkansas Medicaid, Department of Human Services, Donaghey Plaza, P.O. Box 1437, Little Rock, AR 72203
WEBSITE	https://access.arkansas.gov/Learn/HealthCare

California

Medi-Cal

CALL	1-916-552-9200 or 1-800-541-5555
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Medi-Cal, P.O. Box 997417, MS 4607, Sacramento, CA 95899-7417
WEBSITE	https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

Colorado

Health First Colorado

CALL	1-800-221-3943
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Health First Colorado, Department of Health Care Policy & Financing, 1570 N. Grant Street, Denver, CO 80203
WEBSITE	https://www.healthfirstcolorado.com/

Connecticut

Connecticut Department of Social Services

CALL	1-800-842-2159 or 1-866-466-4446
TTY	1-800-842-4524
HOURS	Hours are Mon. – Fri. 7:30 a.m. – 4:00 p.m.
WRITE	Office of the Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144
WEBSITE	https://portal.ct.gov/OHA/Health-Care-Plans/Other-Plans/Medicaid

Delaware

Delaware Health & Social Services

CALL	1-302-255-9500 or 1-800-372-2022
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Delaware Health & Social Services, Division of Medicaid and Medical Assistance, DHSS Herman Holloway Campus, Lewis Building, 1901 N. DuPont Highway, New Castle, DE 19720
WEBSITE	www.dhss.delaware.gov/dhss/dmma/

District of Columbia

Department of Health Care Finance

CALL	1-202-442-5988 or 1-202-727-5355
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:15 a.m. – 4:45 p.m.
WRITE	Department of Health Care Finance, 441 4th Street, NW, 900S, Washington, DC 20001
WEBSITE	https://dhcf.dc.gov/service/medicaid

Florida

Agency For Health Care Administration

CALL	1-877-711-3662
TTY	1-866-467-4970
HOURS	Hours are Mon. - Thur. 8 a.m. – 8 p.m., Fri. 8 a.m. – 7 p.m.
WRITE	Agency For Health Care Administration, P.O. Box 5197, MS 62, Tallahassee, FL 32314
WEBSITE	http://www.flmedicaidmanagedcare.com/

Georgia

Georgia Department of Community Health

CALL	1-404-657-5468
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Georgia Department of Community Health, 2 Peachtree Street NW, Atlanta, GA 30303
WEBSITE	https://medicaid.georgia.gov

Hawaii

Department of Human Services, MedQUEST Division

CALL	1-404-657-5468 or 1-877-423-4746
TTY	711.0
HOURS	Hours are Mon. – Fri. 7:45 a.m. – 4:30 p.m.
WRITE	Med-QUEST, P.O. Box 700190, Kapolei, HI 96709-0190
WEBSITE	https://medquest.hawaii.gov/en/members-applicants/get-started.html

Idaho

Idaho Department of Health and Welfare

CALL	1-808-524-3370 (Oahu) or 1-800-316-8005 (Neighbor Islands)
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Idaho Department of Health and Welfare, 450 W State Street, Boise, ID 83702
WEBSITE	https://healthandwelfare.idaho.gov/services-programs/medicaid-health

Illinois

Illinois Department of Healthcare and Family Services

CALL	1-877-456-1233
TTY	1-800-447-6404
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:45 p.m.
WRITE	Illinois Department of Healthcare and Family Services, 401 South Clinton, Chicago, IL 60607
WEBSITE	https://www2.illinois.gov/hfs/MedicalClients/Pages/medicalprograms.aspx

Indiana

Indiana Medicaid

CALL	1-317-713-9627 or 1-800-457-4584
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Indiana Family & Social Services Administration, Division of Family Resources, Office of Medicaid Policy and Planning, 402 W. Washington Street, P.O. Box 7083, Indianapolis, IN 46207-7083
WEBSITE	http://www.in.gov/medicaid/members/

Iowa

Iowa Medicaid Enterprises

CALL	1-515-256-4606 or 1-800-338-8366
TTY	1-800-735-2942
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Iowa Medicaid Enterprises, 611 5th Avenue, Des Moines, IA 50309, Des Moines, IA 50315
WEBSITE	https://hhs.iowa.gov/ime/about

Kansas

KanCare
CALL 1-800-792-4884
TTY 1-800-792-4292
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE KanCare, P.O. Box 3599, Topeka, KS 66601-9738
WEBSITE www.kancare.ks.gov/

Kentucky

Cabinet for Health and Family Services
CALL 1-855-306-8959
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE Cabinet for Health and Family Services, Department for Medicaid Services, 275 East Main Street, Frankfort, KY 40621
WEBSITE https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx

Louisiana

Louisiana Medicaid
CALL 1-888-342-6207
HOURS Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE Louisiana Medicaid, Louisiana Department of Health, P.O. Box 629, Baton Rouge, LA 70821-0629
WEBSITE https://ldh.la.gov/page/220

Maine

Office of MaineCare Services
CALL 1-855-797-4357
TTY 711.0
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE Office of MaineCare Services, Department of Health and Human Services, 109 Capitol Street, 11 State House Station, Augusta, ME 04333
WEBSITE http://www.maine.gov/dhhs/oms/

Maryland

Maryland Department of Health
CALL 1-410-767-6500 or 1-800-492-5231
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE Maryland Medicaid Administration, Maryland Department of Health, 201 W. Preston Street, Baltimore, MD 21201
WEBSITE https://health.maryland.gov/mmcp/Pages/Am%20I%20Eligible.aspx

Massachusetts

MassHealth
CALL 1-800-841-2900 or 1-877-623-6765
TTY 1-800-497-4648
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE MassHealth, Office of Medicaid, One Ashburton Place, 11th Floor, Boston, MA 02108
WEBSITE www.mass.gov/masshealth

Michigan

Michigan Department of Health & Human Services
CALL 1-517-373-3740
TTY 1-800-649-3777
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE Michigan Department of Health & Human Services, 333 S. Grand Avenue, P.O. Box 30195, Lansing MI 48909
WEBSITE https://www.michigan.gov/mdhhs/assistance-programs/medicaid

Minnesota

Minnesota Department of Human Services
CALL 1-651-431-2670 or 1-800-657-3739
TTY 711.0
HOURS Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155
WEBSITE https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/

Mississippi

Mississippi Division of Medicaid

CALL	1-601-359-6050 or 1-800-421-2408
HOURS	Hours are Mon. – Fri. 7:30 a.m. – 5:00 p.m.
WRITE	Mississippi Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201
WEBSITE	www.medicaid.ms.gov

Missouri

MO HealthNet Division

CALL	1-573-751-3425 or 1-800-392-2161
TTY	1-800-735-2966 or 711
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Missouri Dept of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65102-6500
WEBSITE	http://dss.mo.gov/mhd

Montana

Montana Medicaid

CALL	1-800-362-8312
TTY	1-800-833-8503
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Montana Department of Public Health & Human Services, P.O. Box 202953, Helena, MT 59620-2953
WEBSITE	https://www.dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices

Nebraska

Nebraska Department of Health and Human Services

CALL	1-855-632-7633
TTY	1-402-471-7256
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Nebraska Department of Health and Human Services, Medicaid Dept, 301 Centennial Mall S, Lincoln, NE 68508
WEBSITE	https://dhhs.ne.gov/Pages/Medicaid-Eligibility.aspx

Nevada

Nevada Medicaid

CALL	1-800-992-0900 or 1-877-543-7669
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Nevada Medicaid, Customer Service, P.O. Box 30042, Reno, NV 89520-3042
WEBSITE	https://accessnevada.dwss.nv.gov/public/landing-page

New Hampshire

NH Department of Health and Human Services

CALL	1-844-275-3447
TTY	1-800-735-2964
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Division of Medicaid Services, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301
WEBSITE	https://www.dhhs.nh.gov/programs-services/medicaid

New Jersey

NJ Department of Human Services

CALL	1-800-356-1561
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m.
WRITE	NJ Department of Human Services, Division of Medical Assistance and Health Services, 222 S. Warren Street, Trenton, NJ 08625-0712
WEBSITE	https://www.state.nj.us/humanservices/dmahs/clients/medicaid/

New Mexico

NM Human Services Department's Medical Assistance Division

CALL	1-505-827-3100 or 1-800-283-4465
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	NM Human Services Department's Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504-2348
WEBSITE	https://nmmedicaid.portal.conduent.com/static/index.htm

New York

New York State Department of Health

CALL	1-800-541-2831 or 1-855-355-5777
TTY	1-800-662-1220
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:45 p.m.
WRITE	New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237
WEBSITE	www.health.ny.gov/health_care/medicaid/

North Carolina

NC Division of Health Benefits

CALL	1-888-245-0179
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	NC Medicaid, Division of Health Benefits, 2501 Mail Service Center, Raleigh, NC 27699-2501
WEBSITE	https://ncgov.servicenowservices.com/sp_beneficiary?id=bnf_learn

North Dakota

North Dakota Health and Human Services

CALL	1-701-328-7068 or 1-800-755-2604
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Medical Services Division, North Dakota Health and Human Services, 600 E. Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250
WEBSITE	https://www.hhs.nd.gov/healthcare-coverage/medicaid

Ohio

Ohio Department of Medicaid

CALL	1-800-324-8680
TTY	1-800-292-3572
HOURS	Hours are Mon. – Fri. 7:00 a.m. – 8:00 p.m., Sat. – Sun. 8:00 a.m. – 5:00 p.m.
WRITE	Ohio Department of Medicaid, 50 West Town Street, Suite 400, Columbus, OH 43215
WEBSITE	http://medicaid.ohio.gov/

Oklahoma

Oklahoma Health Care Authority

CALL	1-405-522-7300 or 1-800-987-7767
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105
WEBSITE	https://www.oklahoma.gov/ohca.html

Oregon

Oregon Health Plan

CALL	1-800-699-9075 or 1-800-273-0557
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Oregon Health Plan, Medicaid Division, P.O. Box 14015, Salem, OR 97301-1097
WEBSITE	https://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx

Pennsylvania

Pennsylvania Department of Human Services

CALL	1-717-787-1870 or 1-866-550-4355
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:45 p.m.
WRITE	Pennsylvania Department of Human Services, Office of Medical Assistance Programs, P.O. Box 2675, Harrisburg, PA 17105-2675
WEBSITE	https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx

Puerto Rico

Medicaid Program Department of Health

CALL	1-787-641-4224 or 1-787-765-2929 Ext. 6700
TTY	1-787-625-6955
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 6:00 p.m.
WRITE	Medicaid Program Department of Health, P.O. Box 70184 San Juan, PR 00936-8184
WEBSITE	https://www.medicaid.pr.gov/

Rhode Island

Rhode Island Department of Human Services

CALL	1-401-462-5274 or 1-855-840-4774
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:00 p.m.
WRITE	RI Executive Office of Health and Human Services, 3 West Road, Cranston, RI 02920
WEBSITE	https://eohhs.ri.gov/consumer/health-care

South Carolina

South Carolina Healthy Connections Medicaid

CALL	1-877-552-4642
TTY	1-877-552-4670
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 6:00 p.m., Sat. 9:00 a.m.–12:00 p.m.
WRITE	SC Department of Health and Human Services, South Carolina Healthy Connections Medicaid, P.O. Box 8206, Columbia, SC 29202-8206
WEBSITE	https://www.scdhhs.gov/site-page/medicaid-program-information

South Dakota

South Dakota Department of Social Services

CALL	1-605-773-3165 or 1-877-999-5612
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	South Dakota Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, SD 57501
WEBSITE	https://dss.sd.gov/medicaid/default.aspx

Tennessee

TennCare

CALL	1-800-342-3145 or 1-855-259-0701
TTY	1-877-779-3103
HOURS	Hours are Mon. – Fri. 7:00 a.m. – 6:00 p.m.
WRITE	TennCare, 310 Great Circle Road, Nashville, TN 37243
WEBSITE	https://www.tn.gov/tenncare/members-applicants/eligibility/tenncare-medicaid.html

Texas

Texas Health and Human Services Commission

CALL	1-800-335-8957 or 1-800-252-8263
TTY	1-800-735-2989
HOURS	Hours are Mon. – Fri. 7:00 a.m. – 7:00 p.m.
WRITE	Texas Health and Human Services, P.O. Box 13247, Austin, Texas 78711-3247
WEBSITE	https://www.hhs.texas.gov/services/health/medicaid-chip

Utah

Utah Department of Health

CALL	1-801-538-6155 or 1-800-662-9651
HOURS	Hours are Mon. – Wed., Fri. 8:00 a.m. – 5:00 p.m., Thur. 11:00 a.m. – 5:00 p.m
WRITE	Utah Department of Health, Division of Medicaid and Health Financing, P.O. Box 143106, Salt Lake City, UT 84114-3106
WEBSITE	https://medicaid.utah.gov/

Vermont

Green Mountain Care

CALL	1-800-250-8427
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Green Mountain Care, Department of Vermont Health Access, 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010
WEBSITE	https://dvha.vermont.gov/members/medicaid

Virginia

Department of Medical Assistance Services

CALL	1-833-5CALLVA
TTY	1-888-221-1590
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Department of Medical Assistance Services, Virginia Medicaid, 600 E. Broad Street, Richmond, VA 23219
WEBSITE	https://www.dmas.virginia.gov/

Washington

Washington Apple Health (Medicaid)

CALL	1-800-562-3022
TTY	711.0
HOURS	Hours are Mon. – Fri. 7:00 a.m. – 5:00 p.m.
WRITE	Washington Apple Health (Medicaid), Washington State Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501
WEBSITE	https://www.hca.wa.gov/free-or-low-cost-health-care/apply-or-renew-coverage#apply-magi

West Virginia

West Virginia Bureau for Medical Services

CALL	1-304-558-1700
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	West Virginia Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, WV 25301
WEBSITE	www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Department of Health Services

CALL	1-608-266-1865
TTY	711 or 1-800-947-3529
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Department of Health Services, 1 West Wilson Street, Madison, WI 53703
WEBSITE	https://dhs.wisconsin.gov/medicaid/index.htm

Wyoming

Wyoming Medicaid

CALL	1-307-777-7531 or 1-855-294-2127
TTY	1-307-777-5648
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Wyoming Medicaid, 122 W. 25th Street, 4th Floor West, Cheyenne, WY 82001
WEBSITE	https://health.wyo.gov/healthcarefin/medicaid/

Appendix D: State Pharmaceutical Assistance Programs (SPAP) contact information

Delaware

Chronic Renal Disease Program (CRDP)

CALL	1-302-424-7180 or 1-800-464-4357
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Chronic Renal Disease Program (CRDP), Delaware Health and Social Services (DHSS), 1901 N. Dupont Highway, New Castle, DE 19720
WEBSITE	www.dhss.delaware.gov/dhss/dmma/crdprog.html

Delaware

Delaware Prescription Assistance Program

CALL	1-844-245-9580
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	DPAP, P.O. Box 950, New Castle, DE 19720
WEBSITE	https://dhss.delaware.gov/dhss/dmma/dpap.html

Indiana

HoosierRx

CALL	1-866-267-4679
HOURS	Hours are Mon. – Fri. 7:00 a.m. – 3:00 p.m.
WRITE	HoosierRx, 402 W. Washington, Room 372, Indianapolis, IN 46204
WEBSITE	https://www.in.gov/medicaid/members/member-programs/hoosierrx/

Maine

Maine DEL

CALL	1-800-965-7476
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Maine DEL, Consumers for Affordable Health Care, P.O. Box 2490, Augusta, ME 04338-2490
WEBSITE	https://www.mainecahc.org/guide-to-maine-health-care/other-helpful-programs/help-paying-for-prescriptions/#DEL

Massachusetts

Prescription Advantage

CALL	1-800-243-4636
TTY	1-877-610-0241
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m.
WRITE	Prescription Advantage, P.O. Box 15153, Worcester, MA 01615-0153
WEBSITE	https://www.mass.gov/prescription-drug-assistance

Maryland

Maryland - SPDAP

CALL	1-800-551-5995
TTY	1-800-877-5156
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Maryland - SPDAP, c/o International Software Systems Inc., P.O. Box 749, Greenbelt, MD 20768-0749
WEBSITE	http://marylandspdap.com

Maryland

Maryland Kidney Disease Program

CALL	1-410-767-5000
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Maryland Kidney Disease Program, 201 W. Preston Street, Room SS-3, Baltimore, MD 21201
WEBSITE	www.mdrxprograms.com/kdp.html

Montana

Big Sky Rx Program

CALL	1-866-369-1233
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Big Sky Rx Program, P.O. Box 202915, Helena, MT 59620-2915
WEBSITE	https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky

Montana

Montana Mental Health Services Plan (MHSP)

CALL	1-406-444-3964
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Montana Mental Health Services Plan (MHSP), Behavioral Health and Developmental Disabilities Division, P.O. Box 4210, Helena, MT 59620
WEBSITE	https://dphhs.mt.gov/BHDD/mentalhealthservices/index

Nevada

Nevada Senior Rx

CALL	1-866-303-6323 (option 2)
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Nevada Senior Rx, Aging & Disability Services Division, 3320 W. Sahara Avenue, Suite 100, Las Vegas, NV 89102
WEBSITE	http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

New Jersey

Pharmaceutical Assistance to the Aged and Disabled (PAAD)

CALL	1-800-792-9745
HOURS	24 hour/7 days, automated system
WRITE	Pharmaceutical Assistance to the Aged and Disabled (PAAD), Division of Aging Services, New Jersey Department of Human Services, P.O. Box 715, Trenton, NJ 08625-0715
WEBSITE	http://www.state.nj.us/humanservices/doas/services/paad/

New York

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

CALL	1-800-332-3742
TTY	1-800-290-9138
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	EPIC, P.O. Box 15018, Albany, NY 12212-5018
WEBSITE	www.health.ny.gov/health_care/epic/

Oklahoma

Rx for Oklahoma Prescription Assistance

CALL	1-405-521-2828 or 1-800-763-2828
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Rx for Oklahoma Prescription Assistance, Oklahoma Department of Commerce, 900 N. Stiles Ave., Oklahoma City, OK 73104
WEBSITE	https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/low-income-subsidy-lis-for-prescription-drugs/

Pennsylvania

Pharmaceutical Assistance Contract for the Elderly (PACE)

CALL	1-800-225-7223
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Pharmaceutical Assistance Contract for the Elderly (PACE), P.O. Box 8806, Harrisburg, PA 17105
WEBSITE	http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Pennsylvania

PACE Needs Enhancement Tier (PACENET)

CALL	1-800-225-7223
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	PACE Needs Enhancement Tier (PACENET), P.O. Box 8806, Harrisburg, PA 17105
WEBSITE	http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Pennsylvania

Chronic Renal Disease Program (CRDP)

CALL	1-800-225-7223
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 5:00 p.m.
WRITE	The Chronic Renal Disease Program, Pennsylvania Department of Health, Division of Child and Adult Health Services, 625 Forster St., 7th Floor East Wing, Harrisburg, PA 17120-0701
WEBSITE	http://www.health.pa.gov/

Rhode Island

Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)

CALL	1-401-462-3000 or 1-401-462-0560
TTY	1-401-462-0740
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:00 p.m.
WRITE	Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE), Office of Healthy Aging, 57 Howard Avenue, Louis Pasteur Building, Cranston, RI 02920
WEBSITE	http://oha.ri.gov/

Texas

Kidney Health Care Program

CALL	1-512-776-7150 or 1-800-222-3986
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Kidney Health Care Program, MC 1938, P.O. Box 149030 Austin, TX 78714-9947
WEBSITE	https://hhs.texas.gov/services/health/kidney-health-care

Vermont

Green Mountain Care Prescription Assistance

CALL	1-800-250-8427
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Green Mountain Care, Department of Vermont Health Access, 280 State Drive, NOB 1 South, Waterbury, VT 05671-8100
WEBSITE	https://dvha.vermont.gov/members/prescription-assistance

Wisconsin

SeniorCare

CALL	1-800-657-2038
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 6:00 p.m.
WRITE	SeniorCare, P.O. Box 6710, Madison, WI 53716-0710
WEBSITE	https://dhs.wisconsin.gov/seniorcare/index.htm

Wisconsin

Wisconsin Chronic Renal Disease Program

CALL	1-800-362-3002
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Chronic Renal Disease Program, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Hemophilia Home Care Program

CALL	1-800-362-3002
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Hemophilia Home Care Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Adult Cystic Fibrosis Program

CALL	1-800-362-3002
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Adult Cystic Fibrosis Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Appendix E: AIDS Drug Assistance Programs (ADAP) contact information

Alabama

Alabama AIDS Drug Assistance Program

CALL	1-866-574-9964
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Alabama AIDS Drug Assistance Program, HIV/AIDS Division, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104
WEBSITE	http://www.alabamapublichealth.gov/hiv/adap.html

Alaska

Alaskan AIDS Assistance Association

CALL	1-907-263-2050 or 1-800-478-2437
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m.
WRITE	Alaskan AIDS Assistance Program, 1057 W. Fireweed Lane, Anchorage, AK 99503
WEBSITE	http://www.alaskanaids.org/index.php/client-services/adap

Arizona

Arizona AIDS Drug Assistance Program

CALL	1-602-364-3610 or 1-800-334-1540
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 5:00 p.m.
WRITE	Arizona AIDS Drug Assistance Program, Arizona Department of Health, 150 North 18th Avenue, Suite 130, Phoenix, AZ 85007
WEBSITE	http://www.azdhs.gov/phs/hiv/adap/

Arkansas

Arkansas AIDS Drug Assistance Program

CALL	1-501-661-2408 or 1-888-499-6544
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Arkansas AIDS Drug Assistance Program, Arkansas Department of Health, 4815 W. Markham, Little Rock, AR 72205
WEBSITE	http://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program

California

California AIDS Drug Assistance Program

CALL	1-844-421-7050
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	California AIDS Drug Assistance Program, CDPH, P.O. Box 997377, Mail Stop 0500, Sacramento, CA 95899
WEBSITE	https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx

Colorado

Bridging the Gap, Colorado

CALL	1-303-692-2783
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Bridging the Gap, Colorado-3835, 4300 Cherry Creek Dr. South, Denver, CO 80246-1530
WEBSITE	https://cdphe.colorado.gov/state-drug-assistance-program

Connecticut

Connecticut AIDS Drug Assistance Program

CALL	1-860-509-7806 or 1-800-233-2503
HOURS	Hours are Mon. – Fri. 7:30 a.m. – 4:00 p.m.
WRITE	Connecticut AIDS Drug Assistance Program, Connecticut Department of Public Health, 410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134
WEBSITE	http://www.ct.gov/dph/cwp/view.asp?a=3135&Q=387012

Delaware

Delaware AIDS Drug Assistance Program

CALL	1-302-744-1050
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Delaware AIDS Drug Assistance Program, Delaware Health & Social Services, Division of Public Health, Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901
WEBSITE	http://dhss.delaware.gov/dph/dpc/hivtreatment.html

District of Columbia

DC AIDS Drug Assistance Program

CALL	1-202-671-4900
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:15 a.m. – 4:45 p.m.
WRITE	DC AIDS Drug Assistance Program, District of Columbia Department of Health, 899 North Capitol Street NE, Washington, DC 20002
WEBSITE	https://dchealth.dc.gov/DC-ADAP

Florida

Florida AIDS Drug Assistance Program

CALL	1-850-245-4422 or 1-800-352-2437
TTY	1-888-503-7118
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Florida AIDS Drug Assistance Program, Florida Department of Health, Section of HIV/AIDS and Hepatitis, AIDS Drug Assistance Program, 4052 Bald Cypress Way, BIN A09, Tallahassee, FL 32399
WEBSITE	http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html

Georgia

Georgia AIDS Assistance Program

CALL	1-404-656-9805
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m.
WRITE	Georgia AIDS Assistance Program, Georgia Department of Public Health, 2 Peachtree Street NW, 15th Floor, Atlanta, GA 30303-3186
WEBSITE	http://dph.georgia.gov/adap-program

Hawaii

Hawaii AIDS Drug Assistance Program

CALL	1-808-733-9360
HOURS	Hours are Mon. – Fri. 7:45 a.m. – 4:30 p.m.
WRITE	Hawaii AIDS Drug Assistance Program, Hawaii Department of Health, Harm Reduction Services Branch, 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816
WEBSITE	https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/

Idaho

Idaho AIDS Drug Assistance Program

CALL	1-208-334-5612 or 1-800-926-2588
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Idaho AIDS Drug Assistance Program, Ryan White Part B Program, 450 W. State Street, P.O. Box 83720 Boise, ID 83720-0036
WEBSITE	http://www.healthandwelfare.idaho.gov/Health/FamilyPlanning,STDHIV/HIVCareandTreatment/tabid/391/Default.aspx

Illinois

Illinois AIDS Drug Assistance Program

CALL	1-217-782-4977 or 1-800-825-3518
TTY	1-800-547-0466
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 5:00 p.m.
WRITE	Illinois AIDS Drug Assistance Program, Illinois Department of Public Health, Illinois ADAP Office, 525 West Jefferson Street, Springfield, IL 62761
WEBSITE	https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services

Indiana

Indiana AIDS Drug Assistance Program

CALL	1-866-588-4948
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Indiana AIDS Drug Assistance Program, Indiana State Department of Health, 2 North Meridian Street, Indianapolis, IN 46204
WEBSITE	http://www.in.gov/isdh/17740.htm

Iowa

Iowa AIDS Drug Assistance Program

CALL	1-515-242-5150 or 1-866-227-9878
TTY	711 or 1-800-735-2942
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Iowa AIDS Drug Assistance Program, Iowa Department of Public Health, 321 E. 12th Street, Des Moines, IA 50319-0075
WEBSITE	http://www.idph.iowa.gov/hivstdhep/hiv

Kansas

Kansas AIDS Drug Assistance Program

CALL	1-785-296-5651
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Kansas AIDS Drug Assistance Program, Kansas Department of Health and Environment, 1000 SW Jackson, Suite 210, Topeka, KS 66612
WEBSITE	https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program-ADAP

Kentucky

Kentucky AIDS Drug Assistance Program

CALL	1-502-564-6539 or 1-800-420-7431
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Kentucky AIDS Drug Assistance Program, Kentucky Cabinet for Health and Family Services, Department for Public Health, HIV/AIDS Branch, 275 E. Main St. HS2E-C, Frankfort, KY 40621
WEBSITE	https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana

Louisiana Drug Assistance Program (L-DAP)

CALL	1-504-568-7474
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Louisiana Drug Assistance Program (L-DAP), Louisiana Health Access Program (LA HAP), 1450 Poydras St. , Suite 2136, New Orleans, LA 70112
WEBSITE	http://www.lahap.org/

Maine

Maine AIDS Drug Assistance Program

CALL	1-207-287-3747
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Maine AIDS Drug Assistance Program, Division of Infectious Disease, Center for Disease Control and Prevention, Department of Health and Human Services, 286 Water Street, 11 State House Station, Augusta, ME 04333-0011
WEBSITE	https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/index.shtml

Maryland

Maryland AIDS Drug Assistance Program

CALL	1-410-767-6535 or 1-800-205-6308
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Maryland AIDS Drug Assistance Program, Maryland Department of Health, Center for HIV Care Services, 201 West Preston Street, Baltimore, MD 21201
WEBSITE	https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx

Massachusetts

Massachusetts HIV Drug Assistance Program (HDAP)

CALL	1-617-502-1700 or 1-800-228-2714
HOURS	Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m.
WRITE	Massachusetts HIV Drug Assistance Program (HDAP), Community Research Initiative of New England, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129
WEBSITE	http://crine.org/hdap/

Michigan

Michigan Drug Assistance Program

CALL	1-888-826-6565
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Michigan Drug Assistance Program, HIV Care Section, Division of Health, Wellness and Disease Control, Michigan Department of Health and Human Services, 109 Michigan Avenue, 9th Floor, Lansing, MI 48913
WEBSITE	https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program

Minnesota

Minnesota AIDS Drug Assistance Program

CALL	1-651-431-2414 or 1-800-657-3761
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Minnesota AIDS Drug Assistance Program, Minnesota Department of Human Services, HIV/AIDS Division, P.O. Box 64972, St. Paul, MN 55164-0972
WEBSITE	http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

Mississippi

Mississippi AIDS Drug Assistance Program

CALL	1-601-362-4879 or 1-888-343-7373
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Mississippi AIDS Drug Assistance Program, Mississippi State Department of Health, Office of STD/HIV, P.O. Box 1700, Jackson, MS 39215
WEBSITE	http://msdh.ms.gov/msdhsite/_static/14,13047,150.html

Missouri

Missouri AIDS Drug Assistance Program

CALL	1-573-751-6439
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Missouri AIDS Drug Assistance Program, Missouri Department of Health & Senior Services, Bureau of HIV, STD, and Hepatitis, P.O. Box 570, Jefferson City, MO 65102-0570
WEBSITE	http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

Montana

Montana AIDS Drug Assistance Program

CALL	1-406-444-3565
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Montana AIDS Drug Assistance Program, Montana Department of Public Health and Human Services, HIV/STD Section, P.O. Box 202951, Cogswell Building C211, Helena, MT 59620-2951
WEBSITE	https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog#:~:text=ADAP%20helps%20ensure%20that%20people,see%20the%20ADAP%20Pharmacy%20List.

Nebraska

Nebraska AIDS Drug Assistance Program

CALL	1-402-471-2101
HOURS	Hours are Mon. – Thur. 8:00 a.m. – 5:00 p.m., Fri. 9:00 a.m. – 3:30 p.m.
WRITE	Nebraska AIDS Drugs Assistance Program, Ryan White Program, P.O. Box 95206, Lincoln, NE 68509-5026
WEBSITE	https://dhhs.ne.gov/Pages/HIV-Care.aspx

Nevada

Nevada AIDS Drug Assistance Program

CALL	1-775-684-4025
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Nevada AIDS Drug Assistance Program, Office of HIV/AIDS 1840 E. Sahara Avenue, Suite 110-111, Las Vegas, NV 89104
WEBSITE	https://endhivnevada.org/end-hiv-nevada-program/nevadas-aids-drug-assistance-program-adap/

New Hampshire

New Hampshire AIDS Drug Assistance Program

CALL	1-603-271-4502 or 1-800-852-3345
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	New Hampshire AIDS Drug Assistance Program, New Hampshire Department of Health and Human Services, 29 Hazen Drive, Concord, NH 03301-3852
WEBSITE	http://www.dhhs.nh.gov/dphs/bchs/std/care.htm

New Jersey

New Jersey AIDS Drug Distribution Program (ADDP)

CALL	1-877-613-4533 or 1-800-353-3232
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	New Jersey AIDS Drug Distribution Program (ADDP), New Jersey Department of Health, P.O. Box 360, Trenton, NJ 08625
WEBSITE	http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml

New Mexico

New Mexico AIDS Drug Assistance Program

CALL	1-505-476-3628
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	New Mexico AIDS Drug Assistance Program, 1190 S. St. Francis Drive, Santa Fe, NM 87505
WEBSITE	https://nmhealth.org/about/phd/idb/hats/

New York

New York AIDS Drug Assistance Program

CALL	1-844-682-4058 or 1-800-542-2437
TTY	1-518-459-0121
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	New York AIDS Drug Assistance Program, New York Department of Health, HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052
WEBSITE	http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm

North Carolina

North Carolina HIV Medication Assistance Program (HMAP)

CALL	1-919-733-9161 or 1-877-466-2232
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	North Carolina HIV Medication Assistance Program (HMAP), NC Department of Health and Human Services, Communicable Disease Branch, Epidemiology Section, Division of Public Health, 1902 Mail Service Center, Raleigh, NC 27699-1902
WEBSITE	http://epi.publichealth.nc.gov/cd/hiv/hmap.html

North Dakota

North Dakota Department of Health HIV/AIDS Program

CALL	1-701-328-2378 or 1-800-472-2180
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	North Dakota Department of Health, HIV/AIDS Program, 2635 East Main Ave., Bismarck, ND 58506-5520
WEBSITE	https://www.ndhealth.gov/hiv/

Ohio

Ohio HIV Drug Assistance Program

CALL	1-800-777-4775
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Ohio HIV Drug Assistance Program, Ohio Department of Health, HIV Care Services Section, 246 North High Street, Columbus, OH 43215
WEBSITE	https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/resources/resources

Oklahoma

Oklahoma State Department of Health

CALL	1-405-426-8400 or 1-800-522-0203
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Oklahoma State Department of Health, 123 Robert S. Kerr Ave., Suite 102, Oklahoma City, OK 73102
WEBSITE	https://oklahoma.gov/health/prevention-and-preparedness/sexual-health-and-harm-reduction-service/ryan-white-programs.html

Oregon

CAREAssist

CALL	1-971-673-0144 or 1-800-805-2313
TTY	711.0
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	CAREAssist, Oregon Health Authority, 800 NE Oregon Street, Suite 1105, Portland, OR 97232
WEBSITE	https://public.health.oregon.gov/PHD/Directory/Pages/program.aspx?pid=111

Pennsylvania

Special Pharmaceutical Benefits Program

CALL	1-800-922-9384
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Pennsylvania Department of Health, Special Pharmaceutical Benefits Program, P.O. Box 8808, Harrisburg, PA 17105-8808
WEBSITE	https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx

Puerto Rico

Puerto Rico ADAP

CALL	(787) 765-2929 ext.5106--5137
HOURS	Monday – Friday 8:00am – 5:00pm
WRITE	Departamento de salud, OCASET, Programa Ryan White Parte B, P.O. Box 70184, San Juan, PR 00936-8184
WEBSITE	https://www.salud.gov.pr/CMS/137

Rhode Island

Rhode Island AIDS Drug Assistance Program

CALL	1-401-462-3295
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	Rhode Island AIDS Drug Assistance Program, RI Department of Health, Office of HIV/AIDS & Viral Hepatitis, Executive Office of Health & Human Services, Virks Building, 3 West Road Suite 227, Cranston, RI 02920
WEBSITE	https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx

South Carolina

South Carolina AIDS Drug Assistance Program

CALL	1-800-856-9954
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 5:00 p.m.
WRITE	South Carolina AIDS Drug Assistance Program, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201
WEBSITE	http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/

South Dakota

Ryan White Part B CARE Program

CALL	1-605-773-3737 or 1-800-592-1861
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 5:00 p.m.
WRITE	Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th St., Pierre, SD 57501-1700
WEBSITE	http://doh.sd.gov/diseases/infectious/ryanwhite/

Tennessee

Tennessee HIV Drug Assistance Program (HDAP)

CALL	1-615-532-2392
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Tennessee HIV Drug Assistance Program (HDAP), Tennessee Department of Health, 710 James Robertson Parkway, Andrew Johnson Tower, Nashville, TN 37243
WEBSITE	https://www.tn.gov/health/health-program-areas/std/std/ryanwhite.html

Texas

Texas HIV Medication Program

CALL	1-800-255-1090
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Texas HIV Medication Program, MSJA, MC 1873, P.O. Box 149347, Austin, TX 78714-9347
WEBSITE	http://www.dshs.texas.gov/hivstd/meds/

Utah

Utah AIDS Drug Assistance Program

CALL	1-801-538-6191
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Utah AIDS Drug Assistance Program, Utah Department of Health, Bureau of Epidemiology, 288 North 1460 West, Box 142104, Salt Lake City, UT 84114-2104
WEBSITE	https://ptc.health.utah.gov/treatment/ryan-white/

Vermont

Vermont Medication Assistance Program (VMAP)

CALL	1-802-951-4005
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Vermont AIDS Drug Assistance Program, Vermont Department of Health, HIV/AIDS Program, 108 Cherry Street, Burlington, VT 05402
WEBSITE	HIV Care | Vermont Department of Health (healthvermont.gov)

Virginia

Virginia Medication Assistance Program (VA MAP)

CALL	1-855-362-0658
TTY	711.0
HOURS	Hours are Mon. and Wed. 8:00 a.m. – 6:00 p.m., Tues., Thur. and Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Virginia Medication Assistance Program (VA MAP) Virginia Department of Health, HCS Unit, 1st Floor, 109 Governor Street, Richmond, VA 23219
WEBSITE	https://www.vdh.virginia.gov/disease-prevention/eligibility/

Washington

Early Intervention Program (EIP)

CALL	1-360-236-3426 or 1-877-376-9316
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Early Intervention Program (EIP), Washington State Department of Health, P.O. Box 47841, Olympia, WA 98504-7841
WEBSITE	https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program

West Virginia

West Virginia AIDS Drug Assistance Program

CALL	1-304-232-6822
HOURS	Hours are Mon. – Fri. 8:30 a.m. – 4:30 p.m.
WRITE	West Virginia AIDS Drug Assistance Program ,Jay Adams, HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003
WEBSITE	https://oeps.wv.gov/rwp/pages/default.aspx#adap

Wisconsin

Wisconsin AIDS/HIV Drug Assistance Program

CALL	1-608-267-6875 or 1-800-991-5532
HOURS	Hours are Mon. – Fri. 7:00 a.m. – 4:30 p.m.
WRITE	Wisconsin AIDS/HIV Drug Assistance Program, Wisconsin Division of Public Health, Attn: ADAP, P.O. Box 2659, Madison, WI 53701-2659
WEBSITE	http://www.dhs.wisconsin.gov/aids-hiv/Resources/Overviews/AIDS_HIV_drug_reim.htm

Wyoming

Wyoming AIDS Drug Assistance Program

CALL	1-307-777-6563 or 1-307-777-7529
HOURS	Hours are Mon. – Fri. 8:00 a.m. – 5:00 p.m.
WRITE	Wyoming AIDS Drug Assistance Program, Wyoming Department of Health, 401 Hathaway Building, Cheyenne, WY 82002
WEBSITE	https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/

Multi-language Interpreter Services

English – ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call **1-800-222-6700** (TTY 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-222-6700** (TTY 711).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-222-6700** (TTY 711)

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-222-6700** (TTY: 711).

French Creole – ATANSYON: Si w pale Kreyol Ayisyen, gen sevis ed pou lang ki disponib gratis pou ou. Rele **1-800-222-6700** (TTY: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-222-6700** (TTY: 711) 번으로 전화해 주십시오.

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-222-6700** (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le **1-800-222-6700** (ATS : 711).

Arabic - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-222-6700** (رقم هاتف الصم والبكم 711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-222-6700** (телетайп: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-222-6700** (TTY: 711).

Farsi/Persian - توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد با **1-800-222-6700** (TTY:711) تماس بگیرید.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-222-6700** (TTY: 711).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-222-6700** (TTY: 711).

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-222-6700** (TTY: 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-222-6700** (TTY: 711) まで、お電話にてご連絡ください。

Navajo – Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih **1-800-222-6700** (TTY 711).

Gujarati – સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુ ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલ ધ છે. ફોન કરો **1-800-222-6700** (TTY: 711).

Urdu خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-222-6700** (TTY: 711).

Cigna Secure Rx (PDP) Customer Service

Method	Customer Service – Contact Information
CALL	1-800-222-6700 Calls to this number are free. Hours are 8 a.m.–8 p.m., local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1–September 30. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8 a.m.–8 p.m., local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1–September 30.
FAX	1-800-735-1469
WRITE	Cigna Medicare Prescription Drug Plans, P.O. Box 269005, Weston, FL 33326-9927
WEBSITE	cigna.com/member-resources

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

You can find contact information for the State Health Insurance Assistance Program (SHIP) in your state in Appendix A in the back of this booklet.