January 1 – December 31, 2020

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of VibrantRx (PDP) for the State of Louisiana Office of Group Benefits

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2020. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, VibrantRx, is offered by MG Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means MG Insurance Company. When it says "plan" or "our plan," it means VibrantRx.)

VibrantRx is a Prescription Drug Plan with a Medicare contract offered by MG Insurance Company. Enrollment in VibrantRx depends on contract renewal.

Please contact our Member Services number at 1-844-826-3451 for additional information. (TTY users should call 711.) Hours are 24 hours a day, 365 days a year.

This document may be available in other formats such as Braille, other languages, or other alternate formats. For additional information, call Member Services.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021.

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

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OMB Approval 0938-1051 (Pending OMB Approval)

2020 Evidence of Coverage
Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in VibrantRx, which is a Medicare Prescription Drug Plan

You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, VibrantRx.

There are different types of Medicare plans. VibrantRx 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* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of VibrantRx.

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

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how VibrantRx 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 VibrantRx between January 1, 2020, and December 31, 2020.

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 VibrantRx after December 31, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B) (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are receiving employment-based retiree health coverage from an employer/union group health plan sponsor

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

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

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

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

Section 2.3 Here is the plan service area for VibrantRx

Although Medicare is a Federal program, VibrantRx 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 and the District of Columbia.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or 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 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?

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

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

Front

VibrantRx™ Prescription Drug Plan

RxBIN 015574
RxPCN ASPROD1
RxGrp MVS04-07
Issuer (80840) 9151014609
ID MV000000001
Name <FirstName> <MI> <LastName>
S3285-805

SAMPLE

MedicareRx Prescription Drug Coverage

Back

Member Services 24 hours a day/365 days a year
1-844-826-3451 TTY/TDD: 711

www.MyVibrantRx.com/OGB

Submit pharmacy claims to:
ATTN: CLAIMS DEPARTMENT
VibrantRx
PO Box 509097
San Diego, CA 92150

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 Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

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

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. We included a copy of our Pharmacy Directory in the envelope with this booklet. An updated Pharmacy Directory is located on our website at www.MyVibrantRx.com/OGB.You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network**.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.MyVibrantRx.com/OGB.

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 by VibrantRx. 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 VibrantRx 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 Member Services 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 (www.MyVibrantRx.com/OGB) or call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for VibrantRx

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Your coverage is provided through a contract with the Office of Group Benefits (OGB). For information about your plan premium, please contact the Office of Group Benefits (OGB) Customer Service at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.

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

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

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

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

In some situations, your plan premium could be more than the amount listed above in Section 4.1. Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

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

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

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

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

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

Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay your Part D late enrollment penalty, you could be disenrolled for failure to pay your plan premium. For information about your plan premium, please

contact the Office of Group Benefits (OGB) Customer Service at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.

Section 5.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2020, this average premium amount is $32.74.
- 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 $32.74, which equals $4.58. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

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

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

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

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

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

- For additional information about creditable coverage, please look in your *Medicare & You 2020* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

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

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

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

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

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

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

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

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

Section 6.2 How much is the extra Part D amount?

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

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

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

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

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

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

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

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

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- 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.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit https://www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2020* gives information about the Medicare premiums in the section called "2020 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2020* from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 There are several ways you can pay your plan premium

You are currently enrolled in a group prescription drug plan through a contract with the Office of Group Benefits (OGB). Each month, you will receive a premium bill letting you know how much you need to pay. Please contact your employer group administrator to learn what options are available for you to pay your monthly plan premium, if you have one. If you decide to change the way you pay your premium, you will need to let your plan administrator know. For information about your plan premium, please contact the Office of Group Benefits (OGB) Customer Service at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.

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

Please contact your employer group administrator to find out when your premium is due. If they do not receive your premium in a timely fashion, they will send you a notice telling you that your plan membership will end if we do not receive your premium payment within two calendar months. For information about your plan premium, please contact the Office of Group Benefits (OGB) Customer Service at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

If we end your membership with the plan because you did not pay your premiums, and you don't currently have prescription drug coverage then 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. During the annual Medicare open enrollment period, you may either join a stand-alone

prescription drug plan or a health plan that also provides drug coverage. (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 premiums you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 7 of this booklet tells how to make 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 premiums within our grace period, you can ask us to reconsider this decision by calling 1-844-826-3451, 24 hours a day, 365 days a year. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

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

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If 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 8 Please keep your plan membership record up to date

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

Your membership record has information 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'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 Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call our Coordination of Benefits Call Center at 1-877-384-1251, 8:00 AM - 8:00 PM Eastern, Monday through Friday. TDD/TTY users should call 711.

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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

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

SECTION 10 How other insurance works with our plan

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

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

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

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

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

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

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

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

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 VibrantRx contacts
(how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to VibrantRx Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-844-826-3451 Calls to this number are free. We are open 24 hours a day, 365 days a year. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open 24 hours a day, 365 days a year.
WRITE	VibrantRx PO Box 509097 San Diego, CA 92150
WEBSITE	www.MyVibrantRx.com/OGB

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

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

You may call us if you have questions about our coverage decision process.

How to contact us when you are making an appeal about 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 making an appeal about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

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

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

Contact Information for Coverage Decisions, Appeals and Complaints about Part D Prescription Drugs			
Method	**Coverage Decisions**	**Appeals**	**Complaints (Grievances)**
CALL	1-844-826-3451 Calls to this number are free. We are open 24 hours a day, 365 days a year.		
		We accept expedited appeals by telephone. We do not accept standard appeals by telephone. Standard appeals must be submitted in writing.	
TTY	711 Calls to this number are free. We are open 24 hours a day, 365 days a year.		
FAX	1-858-790-7100	1-858-790-6060	1-858-790-6000
WRITE	ATTN: PA Dept. VibrantRx 10181 Scripps Gateway Ct San Diego, CA 92131	ATTN: Appeals Dept. VibrantRx PO Box 509097 San Diego, CA 92150	ATTN: Grievance Dept. VibrantRx PO Box 509097 San Diego, CA 92150
WEBSITE	www.MyVibrantRx.com/OGB		You can submit a complaint about VibrantRx directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx

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

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

Method	Payment Requests – Contact Information
CALL	*Payment requests must be submitted in writing.* You can request a Direct Member Reimbursement Form (DMR Form) from Member Services by calling 1-844-826-3451. Calls to this number are free. We are open 24 hours a day, 365 days a year.
TTY	*Payment requests must be submitted in writing.* You can request a Direct Member Reimbursement Form (DMR Form) from Member Services by calling 711. Calls to this number are free. We are open 24 hours a day, 365 days a year.
FAX	1-858-549-1569
WRITE	ATTN: CLAIMS DEPARTMENT VibrantRx PO Box 509097 San Diego, CA 92150
WEBSITE	www.MyVibrantRx.com/OGB

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.

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. You can find contact information for the State Health Insurance Assistance Program in your state in **Exhibit A** at the back of this booklet.

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

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

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. You can find contact information for the Quality Improvement Organization in your state in **Exhibit B** at the back of this booklet.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. 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 a 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. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and 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 7:00 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 7:00 am ET to 7:00 pm, Monday through Friday.
WEBSITE	https://www.ssa.gov/

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

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

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

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

To find out more about Medicaid and its programs, contact your state's Medicaid agency listed in **Exhibit C** at the back of this booklet.

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

Medicare's "Extra Help" Program

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

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

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

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

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

- Please call 1-844-826-3451, 24 hours a day, 365 days a year. TTY please dial 711. There are several different documents that Medicare allows as Best Available Evidence to show you qualify for LIS. The document must show you were eligible for **Medicaid** during a month after June of the previous calendar year. These documents include:
  - Copy of your Medicaid card, which includes member name and eligibility date;
  - Copy of a state document that confirms active Medicaid status;
  - Print-out from the State electronic enrollment file showing Medicaid status;
  - Screen print from the State's Medicaid systems showing Medicaid status;
  - Other documentation provided by the State showing Medicaid status;
  - 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;
  - Remittance from a long term care facility showing Medicaid payment for a full calendar month for that individual;
  - Copy of a State document that confirms Medicaid payment to a long term care facility for a full calendar month on behalf of the individual;
  - Screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month's stay for Medicaid payment purposes;
  - Supplemental Security Income (SSI) Notice of Award with an effective date
  - An Important Information letter from Social Security Administration (SSA) confirming that the beneficiary is "...automatically eligible for extra help..."

You may provide one of these documents to us by mail (PO BOX 3835, SCRANTON, PA 18505) or fax (1-855-297-4241) as evidence showing your copayment level.

- 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 Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

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

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

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

The Medicare Coverage Gap Discount Program is available nationwide. Because VibrantRx does not have a coverage gap, the discounts described here do not apply to you.

Instead, the plan continues to cover your drugs at your regular cost-sharing amount until you qualify for the Catastrophic Coverage Stage. Please go to Chapter 4, Section 5 for more information about your coverage during the Initial Coverage Stage.

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

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 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. You can find the contact information for the SPAP(s) in your state in **Exhibit D** at the back of this booklet.

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

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

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. You can find the contact information for the ADAP(s) in your state in **Exhibit E** at the back of this booklet.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the number listed in **Exhibit E** for the ADAP in your area.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

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

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

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in **Exhibit A**) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

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.

You can find the contact information for the SPAP(s) in your state in **Exhibit D** at the back of this booklet.

SECTION 8 How to contact the Railroad Retirement Board

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

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

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 am to 12:00 pm 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	https://secure.rrb.gov/

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.) 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'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 your Part D prescription drugs

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) 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 your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- 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 reference books. (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 To have your prescription covered, use a network pharmacy

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.MyVibrantRx.com/OGB), or call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.MyVibrantRx.com/OGB.

What if you need a specialized pharmacy?

Sometimes 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, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- 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 Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked with the abbreviation "NM" (non-mail order) in our Drug List.

Our plan's mail-order service requires you to order ***at least* an 84-day supply of the drug and *no more than* a 90-day supply**.

A mail order form is included with your Welcome Kit. To get additional information about filling your prescriptions by mail please call our mail order provider, Postal Prescription Services (PPS) Customer Service at 1-800-552-6694, Monday through Friday 6 A.M. to 6 P.M., Pacific Time, and Saturday 9 A.M. to 2:00 P.M., Pacific Time. TTY users, please dial 711. You may also sign up on the web site at www.ppsrx.com. Click on the ORDER PRESCRIPTIONS tab and select Refill, New or Transfer. Fill out the required information and submit the forms. To fill new prescriptions, a hard copy of the prescription is required along with payment. Please fill out the form online and print it.

Mail the form and the prescription(s) to PPS: Postal Prescription Services (PPS), PO Box 2718, Portland, OR 97208-2718. Once PPS has received any new prescriptions and entered them into the system, you will be able to order all future refills online.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your mail order prescription is delayed and you need your prescription immediately, we will work with you to ensure that you receive your prescription. If you have an urgent need for your refill prescription for any reason, you can pay for expedited shipping. In some cases, PPS may be able to request an emergency supply of your prescription from a Kroger-affiliated pharmacy. You may email PPS Customer Service to request an emergency supply or you can call 1-800-552-6694 and speak with a PPS Customer Service Representative for additional help. To e-mail Customer Service, go to www.ppsrx.com, and select "Customer Service" located at the top of the web site. Next, select "Other order questions" and fill in the necessary information, such as prescription number and your requirements. You will receive a prompt response from a PPS Customer Service Representative. You may also call our plan's Member Services, and we will work with you to ensure you receive your prescription.

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

Refills on mail-order prescriptions. For refills, please contact your pharmacy 10 to 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You can share this information with the pharmacy when you place your mail order request or when you first set up your mail order account with the pharmacy. Be sure to keep this information up-to-date. You can call PPS Customer Service at 1-800-552-6694 and speak with a Customer Service Representative for additional help.

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.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs that are *not* available through the plan's mail-order service are marked with the abbreviation **"NM" (non-mail order)** in our Drug List. Our plan's mail-order service requires you to order *at least* an 84-day supply of the drug and *no more than* a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States, but outside of our Plan's service area, and you become ill, lose, or run out of your covered Part D prescription drugs, and cannot access a network pharmacy.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- If you are unable to get a Part D covered drug in a timely manner within our service area. For example, because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- You are provided covered Part D drugs dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.
- During any State or Federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from their place of residence and cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy.
- In unforeseen circumstances in which normal distribution channels are unavailable, we will apply out-of-network policies to facilitate access to medications.
- Physician office access: You are getting a vaccine that is medically necessary but is not covered by Medicare Part B, which is appropriately dispensed and administered in a physician office. Note: You may self-pay the physician for the vaccine cost and submit a paper claim requesting reimbursement. It is also permissible for a third party administrator to assist beneficiaries with the submission of out-of-network claims for vaccines administered in a physician's office.
- We will not reimburse members for Part D medications obtained from an Excluded Provider. We will not routinely allow more than a month's supply of medication to be dispensed at the out-of-network pharmacy. We may require members accessing out-of-network covered Part D drugs and services to assume financial responsibility for any differential between the out-of-network provider's usual and customary price that or the delegated entity's negotiated in network pharmacy service charge. All requests for reimbursement must be made to us in writing.

(See the table entitled Payment Requests in Chapter 2, Section 1, for the address where you may send reimbursement requests.)

- To learn how to submit a paper claim, please refer to the process described at the end of this section. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail-order pharmacy service or through a retail network pharmacy that offers an extended supply. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.
- Before you fill your prescription in any of these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your coinsurance or co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the process described at the end of this section. Members' rights to request reimbursement for out-of-network claims must meet timeframe, notification and effectuation requirements.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

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

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 must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

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

We will generally cover a 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. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

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

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

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

VibrantRx covers four tiers of drugs. **Tier 1: Preferred Generic** is the lowest tier and includes low and medium cost generic drugs. **Tier 2: Preferred Brand** includes lower cost preferred brand drugs. **Tier 3: Non-Preferred Drugs** includes high cost generic and other brand drugs. **Tier 4: Specialty** is the highest tier on our formulary. It contains very high cost brand and generic drugs that may need special handling or close monitoring.

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 Member Services to find out if we cover it.)
2. Visit the plan's website (www.MyVibrantRx.com/OGB). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you

and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

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

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

Section 4.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you *OR* has written "No substitutions" on your prescription for a brand name drug, 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**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

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

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

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

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

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

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

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

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

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

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

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

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer on the plan's Drug List**.

- -- or -- The drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

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

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

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

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

  We will cover a 31-day emergency supply of a non-formulary Part D drugs, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.

- **Current members that are prescribed non-formulary drugs as a result of a change in level of care can be placed in a transition period.** A one-time fill in these scenarios may be accommodated via a manual override at point-of-sale. Level of care changes include the following changes from one treatment setting to another:
  - Entering a long-term care facility from a hospital or other settings;
  - Leaving a long-term care facility and returning to the community;
  - Discharge from a hospital to a home;
  - Ending a stay in a skilled nursing facility covered under Medicare Part A (including pharmacy charges), and revert to coverage under Part D;
  - Reverting from hospice status to standard Medicare Part A and B benefits; and
  - Discharge from a psychiatric hospital with medication regimens that are highly individualized.

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

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services 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. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a 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 and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your 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, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services 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. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception in 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 of our 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 might make changes to the Drug List. For example, the plan might:

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

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

Do changes to your drug coverage affect you right away?

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

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
    - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
    - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
    - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
    - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day supply refill of the drug you are taking at a network pharmacy.
    - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
    - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

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

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

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change 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 restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

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

Section 7.1 Types of drugs we do not cover

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

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

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

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

Also, by law, these categories of drugs are not covered by Medicare drug plans (Your employer group covers certain drugs listed below through our enhanced drug coverage. More information is provided below.):

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

Your employer group offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). Drugs covered by your employer group's supplemental drug coverage are indicated

by 'EX' in your formulary (drug list). To find out which drugs our plan covers and any limitations, refer to your formulary. The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) 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 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

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

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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

Your enrollment in VibrantRx 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 VibrantRx 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 VibrantRx 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?

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

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

Special note about 'creditable coverage':

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" and the choices you have for drug coverage.

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 these notices about creditable coverage, because you may need them 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 a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 7 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or 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) and other programs to help members manage their medications

We have programs that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take. One program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

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

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

CHAPTER 4

What you pay for your Part D prescription drugs

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

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

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.MyVibrantRx.com/OGB. The Drug List on the website is always the most current.
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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

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

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

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

Section 2.1 What are the drug payment stages for VibrantRx members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under VibrantRx. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $6,350. (Details are in Section 5 of this chapter.)	Because there is no coverage gap for the plan, this payment stage does not apply to you.	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2020). (Details are in Section 7 of this chapter.)

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

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

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

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

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

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs 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 you the total drug costs and total payments for your drugs since the year began.

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

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

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

SECTION 4 There is no deductible for VibrantRx

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

There is no deductible for VibrantRx. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (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 four Cost-Sharing Tiers

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

- VibrantRx covers four tiers of drugs. **Tier 1: Preferred Generic** is the lowest tier and includes low and medium cost generic drugs. **Tier 2: Preferred Brand** includes lower cost preferred brand drugs. **Tier 3: Non-Preferred Drugs** includes high cost generic and other brand drugs. **Tier 4: Specialty** is the highest tier on our formulary. It contains very high cost brand and generic drugs that may need special handling or close monitoring.

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

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

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

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

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

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

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

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

Tier	**Standard retail-cost-sharing (in-network)** (up to a 31-day supply)	**Mail-order cost-sharing** (up to a 31-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 31-day supply)
	Before you reach your annual $1,500 prescription OGB out-of-pocket threshold, your share of the cost will be:			
Cost-Sharing Tier 1 (Preferred Generic)	50% coinsurance ($30 maximum)	Mail order not available for 31-day supply	50% coinsurance ($30 maximum)	50% coinsurance ($30 maximum)
Cost-Sharing Tier 2 (Preferred Brand)	50% coinsurance ($55 maximum)	Mail order not available for 31-day supply	50% coinsurance ($55 maximum)	50% coinsurance ($55 maximum)
Cost-Sharing Tier 3 (Non-Preferred Drugs)	65% coinsurance ($80 maximum)	Mail order not available for 31-day supply	65% coinsurance ($80 maximum)	65% coinsurance ($80 maximum)
Cost-Sharing Tier 4 (Specialty)	50% coinsurance ($80 maximum)	Mail order not available for 31-day supply	50% coinsurance ($80 maximum)	50% coinsurance ($80 maximum)
	After you reach your annual $1,500 prescription OGB out-of-pocket threshold, your share of the cost will be:			
Cost-Sharing Tier 1 (Preferred Generic)	$0	Mail order not available for 31-day supply	$0	$0
Cost-Sharing Tier 2 (Preferred Brand)	$20 copayment	Mail order not available for 31-day supply	$20 copayment	$20 copayment
Cost-Sharing Tier 3 (Non-Preferred Drugs)	$40 copayment	Mail order not available for 31-day supply	$40 copayment	$40 copayment
Cost-Sharing Tier 4 (Specialty)	$40 copayment	Mail order not available for 31-day supply	$40 copayment	$40 copayment

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

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

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

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

- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
    - Here's an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is $31. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

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

Section 5.4 A table that shows your costs for a *long-term* up to a 93-day supply of a drug

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

The table below shows what you pay when you get a long-term up to a 93-day supply of a drug.

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

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

Tier	**Standard retail cost-sharing (in-network)** (up to a 93-day supply)	**Mail-order cost-sharing** (up to a 93-day supply)
	<u>Before</u> you reach your annual $1,500 prescription OGB out-of-pocket threshold, your share of the cost will be:	
Cost-Sharing Tier 1 (Preferred Generic)	50% coinsurance ($75 maximum)	50% coinsurance ($75 maximum)
Cost-Sharing Tier 2 (Preferred Brand)	50% coinsurance ($137.50 maximum)	50% coinsurance ($137.50 maximum)
Cost-Sharing Tier 3 (Non-Preferred Drugs)	65% coinsurance ($200 maximum)	65% coinsurance ($200 maximum)
Cost-Sharing Tier 4 (Specialty)	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4
	<u>After</u> you reach your annual $1,500 prescription OGB out-of-pocket threshold, your share of the cost will be:	
Cost-Sharing Tier 1 (Preferred Generic)	$0	$0
Cost-Sharing Tier 2 (Preferred Brand)	$50 copayment	$50 copayment
Cost-Sharing Tier 3 (Non-Preferred Drugs)	$100 copayment	$100 copayment
Cost-Sharing Tier 4 (Specialty)	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $6,350

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $6,350. Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $6,350, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Your employer group offers additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count toward your total out-of-pocket costs. To find out which drugs our plan covers, refer to your formulary.

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $6,350 limit in a year.

We will let you know if you reach this $6,350 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Section 5.6 How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $6,350, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

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

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

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

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your 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 $6,350 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

- The amount you pay for 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.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

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

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

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $6,350 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage 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 6 There is no coverage gap for VibrantRx

Section 6.1 You do not have a coverage gap for your Part D drugs

There is no coverage gap for VibrantRx. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

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

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

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $6,350 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

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

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the ***smaller*** amount between:
  - – *either* – Your normal tier copayment or coinsurance
  - - *or* –5% coinsurance on the cost of the drug OR a copayment of $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs, whichever is the *larger* amount.
- **Our plan pays the rest** of the cost.

For drugs offered under your employer group's enhanced benefit (excluded from Part D), you will continue to pay the applicable tier copayment or coinsurance during the Catastrophic Coverage Stage.

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

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

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

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

What do you pay for a Part D vaccination?

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

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

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

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

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

To show how this works, here are three common ways you might get a Part D vaccine.

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

- You will have to pay the pharmacy the amount of your coinsurance OR copayment for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

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

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

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

Section 8.2 You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

CHAPTER 5

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

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

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

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

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

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

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

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

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

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 *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

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

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

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

SECTION 2 How to ask us to pay you back

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

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

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.MyVibrantRx.com/OGB) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

ATTN: CLAIMS DEPARTMENT

VibrantRx

PO Box 509097

San Diego, CA 92150

You must submit your claim to us within 90 days of the date you received the service, item, or drug.

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

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

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

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

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

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and

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

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

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

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

Here is a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

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

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

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

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with VibrantRx Member Services at 1-844-826-3451. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact VibrantRx Member Services at 1-844-826-3451 for additional information.

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

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.

- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your 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 Member Services (phone numbers are printed on the back cover of this booklet).

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

As a member of VibrantRx, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the VibrantRx pharmacy directory.
  - For more detailed information about our pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at www.MyVibrantRx.com/OGB.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be

covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate agency for your state listed in **Exhibit F.**

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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

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

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 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 Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, 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 users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, 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: https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
    - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You must pay your plan premiums to continue being a member of our plan. For information about your plan premium, please contact the Office of Group Benefits (OGB) Customer Service at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.
    - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) *OR* coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your Part D prescription drugs.
    - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.

  - 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 pay the extra amount directly to the government to remain a member of the plan.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

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

BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in **Exhibit A** of this booklet.

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

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

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

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

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

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

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

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

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

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

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the 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 reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

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

Part D coverage decisions and appeals

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

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

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

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

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

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

Which of these situations are you in?

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

Section 5.2 What is an exception?

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

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are 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 *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

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

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3: 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 on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

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

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

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

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

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  - If the drug you're taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.
  - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
  - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 4: Specialty tier.
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request that asks us to pay for our share of the cost for a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs.* Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.

- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

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

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

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

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

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
    - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
    - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
    - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to 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 organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

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

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

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

What to do

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

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

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

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

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

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

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.

- If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

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

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

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

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

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

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

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

Deadlines for "fast appeal" at Level 2

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

Deadlines for "standard appeal" at Level 2

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

- **If the Independent Review Organization says yes to part or all of what you requested**
- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

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

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

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

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

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

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

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

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

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

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

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

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

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

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

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

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**

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

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. TTY please dial 711. We are open 24 hours a day, 365 days a year.
- **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.
- **Once you have called us or written to us about your complaint, we will do the rest.** We will investigate your issues and notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

  Complaints about decisions to not conduct expedited coverage determinations or redeterminations will automatically be considered a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint**. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

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

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

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

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

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

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

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).

- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

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

Section 7.5 You can also tell Medicare about your complaint

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

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

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

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

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

Important: you will lose your medical and prescription drug coverage through OGB if you are disenrolled from this plan, or if you are disenrolled because of coverage in another Medicare prescription drug plan or Medicare Advantage plan. **You will not be permitted to re-enroll in the future**. If you are the retiree, your covered spouse and children will also lose their medical and prescription drug coverage. If you have questions, contact OGB's customer service department at 1-800-272-8451.

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

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

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

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan.
        - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a 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 VibrantRx 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 VibrantRx 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.

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

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

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

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (https://www.medicare.gov):
  - If you have moved out of your plan's service area.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (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 Member Services (phone numbers are printed on the back cover of this booklet).

  Note: If you're in a drug management program, you may not be able to change plans.
  - Chapter 3, Section 10 tells you more about drug management programs.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a 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 VibrantRx 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 VibrantRx 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.

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

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

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

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2020*** Handbook.
    - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
    - You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

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

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

Important: you will lose your medical and prescription drug coverage through OGB if you are disenrolled from this plan, or if you are disenrolled because of coverage in another Medicare prescription drug plan or Medicare Advantage plan. **You will not be permitted to re-enroll in the future**. If you are the retiree, your covered spouse and children will also lose their medical and prescription drug coverage. If you have questions, contact OGB's customer service department at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. You will automatically be disenrolled from VibrantRx when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from VibrantRx 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 VibrantRx 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 Member Services (phone numbers are printed on the back cover of this booklet) 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).

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan. **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • 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

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

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

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

SECTION 5 VibrantRx must end your membership in the plan in certain situations

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

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

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you do not pay the plan premiums for two calendar months.
  - We must notify you in writing that you have 2 calendar months to pay the plan premium before we end your membership. For information about your plan premium, please contact the Office of Group Benefits (OGB) Customer Service at 1-800-272-8451. TTY/TDD users please dial 711. Hours are Monday through Friday, from 8:00 am to 4:30 pm, Central time.
- 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:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

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

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

What should you do if this happens?

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

Section 5.3 You have the right to make a complaint if we end your membership in 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 file a grievance or can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within our 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.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services 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, VibrantRx, 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 Fraud, waste and abuse reporting

Fraud, waste and abuse are growing problems in health care and cause health care costs to rise for everyone. Health care fraud, waste and abuse should be reported. "Fraud" is when a provider or plan member is involved in purposely submitting wrong or misleading information that causes them to receive payment they would otherwise not be entitled to. Waste and abuse are when health care supplies and services are used without need or they are used more than needed. If you know of or suspect insurance fraud, waste and/or abuse, please call our **Anonymous Fraud, Waste & Abuse Hotline at 1-888-274-1370.**

SECTION 5 Our plan as secondary payer

When you have other prescription drug coverage, Medicare allows our plan to coordinate coverage with your other plan. This is called Coordination of Benefits. For example, if you have suffered a job-related injury or illness and you are receiving workers' compensation benefits, workers' compensation must provide its benefits first for any prescription drug costs related to your job-related illness or injury before our plan provides benefits. Whether we pay first or second depends on what other types of insurance you have and the Medicare rules that apply to your situation. For more information, you can refer to the government brochure, *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You can get a copy of this brochure at https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf or by calling Medicare at 1-800-MEDICARE (1-800-633-4227).

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. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $6,350 in covered drugs during the covered year.

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

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

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

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

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four 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 booklet. Chapter 7 explains how to ask us for a coverage decision.

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

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

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. This means you pay $1 for each day's supply when you fill your prescription.

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

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

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

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

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

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

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

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

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

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 out-of-pocket costs for the year have reached $6,350.

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

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

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

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

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

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

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

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. For this reason, most, but not all, brand name drugs are discounted.

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

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

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

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

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

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

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

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

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by 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 care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a late enrollment penalty.

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 that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

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

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

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we 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.

Exhibit A: State Health Insurance Assistance Programs (SHIP)

ALABAMA
State Health Insurance Assistance Program (SHIP)
Alabama Department of Senior Services
201 Monroe Street, Suite 350
Montgomery, AL 36104
Toll free: 1-800-AGELINE (1-800-243-5463)
TTY: 711
Website: http://www.alabamaageline.gov

ALASKA
Alaska State Health Insurance Assistance Program (SHIP)
Alaska Medicare Information Office
550 W. 7th Ave., Suite 1230
Anchorage, AK 99501
Toll free: 1-800-478-6065 / Local: 1-907-269-3680 (Anchorage)
TTY: 1-800-770-8973 or 711
Website:http://dhss.alaska.gov/dsds/pages/medicare/default.aspx

ARIZONA
State Health Insurance Assistance Program (SHIP)
Arizona Department of Economic Security
Division of Aging and Adult Services
1789 W Jefferson St., Site Code 950A
Phoenix, AZ 85007
Toll free: 1-800-432-4040 / Local: 1-602-542-4446
TTY: 711
Website: https://des.az.gov/services/aging-and-adult/state-health-insurance-assistance-program-ship

ARKANSAS
Senior Health Insurance Information Program (SHIIP)
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
Toll free: 1-800-224-6330 / Local: 1-501-371-2782
TTY: 711
Website: https://insurance.arkansas.gov/pages/consumer-services/senior-health/

CALIFORNIA
Health Insurance Counseling & Advocacy Program (HICAP)
California Department of Aging
1300 National Drive, Suite 200
Sacramento, CA 95834-1992
Toll Free: 1-800-434-0222
Local: 1-916-419-7500
TTY: 1-800-735-2929
Website: https://www.aging.ca.gov/hicap/

COLORADO
State Health Insurance Assistance Program (SHIP)
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
Toll free: 1-888-696-7213 en Español, 1-866-665-9668
Local: 1-303-894-7499
TTY: 711
Website: https://www.colorado.gov/dora/senior-healthcare-medicare

CONNECTICUT
CHOICES
Department of Rehabilitation Services, State Unit on Aging
55 Farmington Avenue
Hartford, CT 06105-3730
Toll free: 1-800-994-9422
Local: 1-860-424-5274
TTY: 711
Website: http://www.ct.gov/agingservices/

DELAWARE
Delaware Medicare Assistance Bureau (DMAB)
841 Silver Lake Blvd.
Dover, DE 19904
Toll free: 1-800-336-9500
Local: 1-302-674-7364
TTY: 711
Website: https://insurance.delaware.gov/divisions/dmab/

DISTRICT OF COLUMBIA
Health Insurance Counseling Project (HICP)
Department of Aging
500 K Street, NE
Washington, DC 20002
Local: 1-202-727-8370
TTY: 711
Website: https://dcoa.dc.gov/service/health-insurance-counseling

FLORIDA
Serving Health Insurance Needs of Elders (SHINE)
Department of Elder Affairs
4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000
Toll free: 1-800-96-ELDER (1-800-963-5337)
TTY: 1-800-955-8770
Website: http://www.floridashine.org/

GEORGIA
GeorgiaCares
2 Peachtree Street, NW, 33rd Floor
Atlanta, GA 30303
Toll free: 1-866-552-4464 (Option 4)
TTY: 711
Website: http://www.mygeorgiacares.org/

HAWAII
Hawaii SHIP Executive Office on Aging
No. 1 Capitol District
250 South Hotel Street, Suite 406
Honolulu, HI 96813-2831
Toll free: 1-888-875-9229 / Local: 1-808-586-7299 (Oahu)
TTY: 1-866-810-4379
Website: http://www.hawaiiship.org/

IDAHO
Senior Health Insurance Benefits Advisors (SHIBA)
Central Office
700 West State Street
Boise, ID 83720-0043
Toll free: 1-800-247-4422 / Local: 1-208-334-4250
TTY: 711
Website: https://doi.idaho.gov/SHIBA/default

ILLINOIS
Senior Health Insurance Program (SHIP)
Illinois Department on Aging
One Natural Resources Way,Suite100
Springfield, IL 62702-1271
Toll free: 1-800-252-8966
TTY: 1-888-206-1327
Website:
https://www2.illinois.gov/aging/ship/Pages/default.aspx

INDIANA
State Health Insurance Assistance Program (SHIP)
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787
Toll free: 1-800-452-4800
TTY: 1-866-846-0139
Website: https://www.in.gov/idoi/2495.htm

IOWA
Senior Health Insurance Information Program (SHIIP)
601 Locust St. - 4th Floor
Des Moines, IA 50309-3738
Toll free: 1-800-351-4664
TTY: 1-800-735-2942
Website: http://www.therightcalliowa.gov/

KANSAS
Senior Health Insurance Counseling for Kansas (SHICK)
New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404
Toll free (in Kansas only): 1-800-860-5260
Local: 1-785-296-4986
TTY: 711
Website:
http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

KENTUCKY
State Health Insurance Assistance Program (SHIP)
Cabinet for Health and Family Services
275 E. Main Street
Frankfort, KY 40621
Toll free: 1-800-372-2973 or 1-877-293-7447
Local: 1-502-564-5497 or 1-502-564-6930
TTY: 711
Website: https://chfs.ky.gov/agencies/dail/Pages/ship.aspx

LOUISIANA
Senior Health Insurance Information Program (SHIIP)
1702 N. 3rd Street
Baton Rouge, LA 70802
Toll free: 1-800-259-5300 / Local: 1-225-342-5900
TTY: 711
Website: http://www.ldi.la.gov/consumers/senior-health-shiip

MAINE
Maine State Health Insurance Assistance Program (SHIP)
OADS Aging Services, Maine DHHS
11 State House Station, 41 Anothony Avenue
Augusta, ME 04333
Toll free: 1-800-262-2232 or 1-888-568-1112
Local: 1-207-287-9200
TTY: 711
Website: http://www.maine.gov/dhhs/oads/community-support/ship.html

MARYLAND
State Health Insurance Assistance Program (SHIP)
The Maryland Department of Aging
301 W Preston Street, Suite 1007
Baltimore, MD 21201
Toll free: 1-800-243-3425 or 1-844-627-5465
Local: 1-410-767-1100
TTY: 711
Website: http://aging.maryland.gov/Pages/StateHealthInsuranceProgram.aspx

MASSACHUSETTS
SHINE (Serving Health Insurance Needs of Everyone)
Executive Office of Elder Affairs
One Ashburton Place, 5th Floor
Boston, MA 02108
Toll free: 1-800-243-4636
Local: 1-617-727-7750
TTY: 1-877-610-0241 or 711
Website: https://www.mass.gov/health-insurance-counseling

MICHIGAN
Michigan Medicare/Medicaid Assistance Program
(MMAP, Inc.)
6105 West St. Joseph Hwy, Suite 204
Lansing, MI 48917
Toll free: 1-800-803-7174
TTY: 711
Website: http://mmapinc.org/

MINNESOTA
Minnesota State Health Insurance Assistance
Program/Senior LinkAge Line; Minnesota Board on Aging
Elmer L. Anderson Human Services Building
540 Cedar Street
St. Paul, MN 55155
Toll free: 1-800-333-2433 or 1-800-882-6262
Local: 1-651-431-2500
TTY: 1-800-627-3529
Website: https://www.minnesotahelp.info/Index

MISSISSIPPI
MS State Health Insurance Assistance Program (SHIP)
MS Department of Human Services,
Division of Aging and Adult Services
200 South Lamar St.
Jackson, MS 39201
Toll free: 1-844-822-4622
Local: 1-601-359-4500
TTY: 711
Website: http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

MISSOURI
CLAIM, State Health Insurance Assistance Program (SHIP)
200 North Keene Street, Suite 101
Columbia, MO 65201
Toll free: 1-800-390-3330
Local: 1-573-817-8320
TTY: 711
Website: http://missouriclaim.org/

MONTANA
Montana State Health Insurance Assistance Program (SHIP)
Montana DPHHS
1100 N Last Chance Gulch, 4th Floor
Helena, MT 59601
Toll free: 1-800-551-3191/Local: 1-406-444-4077
TTY: 711
Website: https://dphhs.mt.gov/sltc/services/aging/ship.aspx

NEBRASKA
NE Senior Health Insurance Information Program (SHIIP)
Nebraska Department of Insurance
PO Box 82089
Lincoln, NE 68501-2089
Toll free: 1-800-234-7119 / Local: 1-402-471-2201
TTY: 711
Website: https://doi.nebraska.gov/consumer/senior-health

NEVADA
State Health Insurance Assistance Program (SHIP)
Nevada Aging and Disability Services Division
3416 Goni Road, Suite D-132
Carson City, NV 89706
Toll free: 1-800-307-4444 / Local: 1-775-687-4210
TTY: 711
Website:
http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/

NEW HAMPSHIRE
NH SHIP – ServiceLink Aging and Disability
Resource Center
Bureau of Elderly & Adult Services, DHHS
129 Pleasant St.
Concord, NH 03301
Toll free: 1-866-634-9412
TTY: 711
Website:
https://www.servicelink.nh.gov/medicare/index.htm

NEW JERSEY
State Health Insurance Assistance Program (SHIP)
Division of Aging Services
New Jersey Department of Human Services
PO Box 715
Trenton, NJ 08625-0715
Toll free: 1-800-792-8820 / Local: 1-877-222-3737
TTY: 711
Website:
http://www.state.nj.us/humanservices/doas/services/ship/index.html

NEW MEXICO
Benefits Counseling Program
NM Aging & Long Term Services Dept.
2550 Cerrillos Road
Santa Fe, NM 87505
Toll free: 1-800-432-2080 / Local: 1-505-476-4799
TTY: 711 or 1-505-476-4937
Website: http://www.nmaging.state.nm.us/

NEW YORK
Health Insurance Information Counseling & Assistance Program (HIICAP)
NY State Office for the Aging
2 Empire State Plaza
Albany, NY 12223-1251
Toll free: 1-800-701-0501 / Local: 1-800-342-9871
TTY: 711
Website: https://aging.ny.gov/healthbenefits/

NORTH CAROLINA
Seniors' Health Insurance Information Program (SHIIP)
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free: 1-855-408-1212
TTY: 711
Website: http://www.ncshiip.com/

NORTH DAKOTA
Senior Health Insurance Counseling (SHIC)
North Dakota Insurance Department
600 E. Boulevard Ave., Fifth Floor
Bismarck, ND 58505-0320
Toll free: 1-888-575-6611 / Local: 1-701-328-2440
TTY: 1-800-366-6888
Website: http://www.nd.gov/ndins/shic

OHIO
Ohio Senior Health Insurance Information Program (OSHIIP)
50 W Town Street, Third Floor, Suite 300
Columbus, OH 43215
Toll free: 1-800-686-1578
TTY: 1-614-644-3745
Website: http://www.insurance.ohio.gov

OKLAHOMA
Senior Health Insurance Counseling Program (SHIP)
Five Corporate Plaza
3625 NW 56th, Suite 100
Oklahoma City, OK 73112-4511
Toll free: 1-800-763-2828 (in state only) /
Local: 1-405-521-6628
TTY: 711
Website: http://www.map.oid.ok.gov

OREGON
Senior Health Insurance Benefits Assistance (SHIBA)
350 Winter Street NE, Room 300
PO Box 14480
Salem, OR 97309-0405
Toll free: 1-800-722-4134
TTY: 711
Website: http://www.oregonshiba.org

PENNSYLVANIA
APPRISE
Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919
Toll free: 1-800-783-7067 / Local: 1-717-783-1550
TTY: 711
Website: http://www.agingpa.gov

RHODE ISLAND
Senior Health Insurance Program (SHIP), RI DHS
Rhode Island Department of Human Services
57 Howard Ave.
Louis Pasteur Bldg. 2nd Floor
Cranston, RI 02920
Toll free: 1-888-884-8721
Local: 1-401-462-3000
TTY: 1-401-462-0740
Website: http://www.dea.ri.gov/insurance/

SOUTH CAROLINA
South Carolina Department on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201
Toll free: 1-800-868-9095
Local: 1-803-734-9900
TTY: 711
Website: http://www.aging.sc.gov/

SOUTH DAKOTA
Senior Health Information and Insurance Education (SHIINE)
800 E. Dakota
Pierre, SD 57501
Toll free: 1-877-331-4834 (Central South Dakota); 1-800-536-8197 (E. South Dakota); 1-877-286-9072 (W. South Dakota)
Local: 1-605-494-0219 (Central South Dakota); 1-605-333-3314 (E. South Dakota); 1-605-342-8635 (W. South Dakota)
TTY: 711
Website: http://www.shiine.net/

TENNESSEE
TN State Health Insurance Assistance Program
Tennessee Commission on Aging and Disability
502 Deaderick Street, 9th Floor
Nashville, TN 37243-0860
Toll free: 1-877-801-0044
Local: 1-615-741-2056
TTY: 711 or 1-800-848-0299
Website: http://tnmedicarehelp.com/

TEXAS
Texas Health and Human Services (HHS)
Brown Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316
Toll free: 1-800-252-9240
TTY: 711 or 1-800-735-2989
Website: https://www.hhs.texas.gov/Medicare

UTAH
Utah Department of Human Services
Senior Health Insurance Information Program (SHIP)
Aging Services Administration Office
195 North 1950 West
Salt Lake City, UT 84116
Toll free: 1-800-541-7735 or 1-877-424-4640
Local: 1-801-538-3910
TTY: 711
Website: https://www.daas.utah.gov/seniors/

VERMONT
Vermont Association of Area Agencies on Aging
476 Main Street, Suite #3
Winooski, VT 05404
Toll free: 1-800-642-5119
Local: 1-802-865-0360 or 1-802-578-7094
TTY: 711
Website: http://www.vermont4a.org

VIRGINIA
Virginia Insurance Counseling and Assistance Program (VICAP)
The Office for Aging Services
1610 Forest Avenue, Suite 100
Henrico, VA 23229
Toll free: 1-800-552-3402 / Local: 1-804-662-9333
TTY: 711
Website: https://www.vda.virginia.gov/vicap.htm

WASHINGTON
Statewide Health Insurance Benefits Advisors (SHIBA)
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
Toll free: 1-800-562-6900
TTY: 1-360-586-0241
Website: https://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/

WEST VIRGINIA
West Virginia State Health Insurance Assistance Program
1900 Kanawha Boulevard East
Charleston, WV 25305
Toll free: 1-877-987-4463
Local: 1-304-558-3317
TTY: 711
Website: http://www.wvship.org/

WISCONSIN
WI State Health Insurance Assistance Program
Department of Health Services
1 West Wilson Street
Madison, WI, 53703
Toll Free: 1-800-242-1060 (Medigap and Medicare questions) or 1-855-677-2783
Local: 1-608-266-1865
TTY: 1-888-758-6049 (Part D questions for people 60+) or 1-800-926-4862 (Part D questions for people with disabilities)
Website: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

WYOMING
Wyoming State Health Insurance Information Program (WSHIIP)
106 West Adams Avenue
Riverton, WY 82501
Toll free: 1-800-856-4398
Local: 1-307-856-6880
TTY: 711
Website: http://www.wyomingseniors.com/

Exhibit B: Quality Improvement Organization (QIO)

Please review the choices below for the QIO serving your state of residence.

REGION 1: CONNECTICUT, MAINE, MASSACHUSETTS, NEW HAMPSHIRE, RHODE ISLAND, VERMONT
KEPRO
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
Toll Free: 1-888-319-8452
TTY: 1-855-843-4776
Fax: 1-833-868-4055
Web site: https://www.keproqio.com

REGION 2: NEW JERSEY, NEW YORK
Livanta LLC BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Toll Free: 1-866-815-5440
TTY: 1-866-868-2289
Fax: 1-833-868-4056
Web site: https://www.livantaqio.com

REGION 3: DELAWARE, DISTRICT OF COLUMBIA, MARYLAND, PENNSYLVANIA, VIRGINIA, WEST VIRGINIA
Livanta LLC BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Toll Free: 1-888-396-4646
TTY: 1-888-985-2660
Fax: 1-833-868-4057
Web site: https://www.livantaqio.com

REGION 4: ALABAMA, FLORIDA, GEORGIA, KENTUCKY, MISSISSIPPI, NORTH CAROLINA, SOUTH CAROLINA, TENNESSEE
KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll Free: 1-888-317-0751
TTY: 1-855-843-4776
Fax: 1-833-868-4058
Web site: https://www.keproqio.com

REGION 5: ILLINOIS, INDIANA, MICHIGAN, MINNESOTA, OHIO, WISCONSIN
Livanta LLC BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Toll Free: 1-888-524-9900
TTY: 1-888-985-8775
Fax: 1-833-868-4059
Web site: https://www.livantaqio.com

REGION 6: ARKANSAS, LOUISIANA, NEW MEXICO, OKLAHOMA, TEXAS
KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll Free: 1-888-315-0636
TTY: 1-855-843-4776
Fax: 1-833-868-4060
Web site: https://www.keproqio.com

REGION 7: IOWA, KANSAS, MISSOURI, NEBRASKA
Livanta LLC BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Toll Free: 1-888-755-5580
TTY: 1-888-985-9295
Fax: 1-833-868-4061
Web site: https://www.livantaqio.com

REGION 8: COLORADO, MONTANA, NORTH DAKOTA, SOUTH DAKOTA, UTAH, WYOMING
KEPRO
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
Toll Free: 1-888-317-0891
TTY: 1-855-843-4776
Fax: 1-833-868-4062
Web site: https://www.keproqio.com

REGION 9: ARIZONA, CALIFORNIA, HAWAII, NEVADA
Livanta LLC BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Toll Free: 1-877-588-1123
TTY: 1-855-887-6668
Fax: 1-833-868-4063
Web site: https://www.livantaqio.com

REGION 10: ALASKA, IDAHO, OREGON, WASHINGTON
KEPRO
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
Toll Free: 1-888-305-6759
TTY: 1-855-843-4776
Fax: 1-833-868-4064
Web site: https://www.keproqio.com

Exhibit C: State Medicaid Agencies

ALABAMA
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36104
Toll free: 1-800-362-1504
Local: 1-334-242-5000
TTY: 711
Website: www.medicaid.alabama.gov

ALASKA
Dept. of Health and Social Services
350 Main Street, Room 304
PO Box 110640
Juneau, AK 99811-0640
Toll free: 1-800-770-5650
Local: 1-907-465-5847
TTY: 711 or 1-907-465-3347
Website: http://dhss.alaska.gov/dpa/Pages/medicaid

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)
801 E. Jefferson Street
Phoenix, AZ 85034
Toll free: 1-800-654-8713 (in-state)
Toll free: 1-800-523-0231 (out of state)
Local: 1-602-417-4000
TTY: 711 or 1-800-367-8939
Website: www.azahcccs.gov

ARKANSAS
Arkansas Division of Medical Services
Department of Human Services
Donaghey Plaza South
P. O. Box 1437, Slot S401
Little Rock, AR 72203-1437
Toll free: 1-800-482-5431 or 1-800-482-8988
Local: 1-501-682-8501 or 1-501-682-8233
TTY: 711
Website: https://medicaid.mmis.arkansas.gov

CALIFORNIA
Medi-Cal Managed Care Division
PO Box 997413 MS 4400
Sacramento, CA 95899-7413
Toll free: 1-800-786-4346 or 1-888-452-8609
Local: 1-916-449-5000
TTY: 711
Website: www.dhcs.ca.gov

COLORADO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818
Toll free: 1-800-221-3943
Local: 1-303-866-2993
TTY: 711
Website: www.colorado.gov/hcpf

CONNECTICUT
HUSKY Health Program
55 Farmington Ave.
Hartford, CT 06105-3730
Toll free: 1-877-284-8759 / Local: 1-860-424-4908
TTY: 1-866-492-5276
Website: www.ct.gov/dss

DELAWARE
DHSS Herman Holloway Campus, Lewis Bldg.
1901 N DuPont Highway
New Castle, DE 19720
Toll free: 1-800-372-2022 / Local: 1-302-255-9500
TTY: 711
Website: www.dhss.delaware.gov/dmma/

DISTRICT OF COLUMBIA
DC Health
899 North Capitol Street, NE
Washington, DC 20002
Toll free: 1-855-532-5465
Local: 1-202-442-5955
TTY: 711
Website: https://dchealth.dc.gov

FLORIDA
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
Toll free: 1-888-419-3456 / Local: 1-850-412-4000
TTY: 711 or 1-800-955-8771
Website: www.ahca.myflorida.com

GEORGIA
GA Department of Community Health
2 Peachtree St NW
Atlanta, GA 30303
Toll Free: 1-866-211-0950 or 1-877-423-4746
Local: 1-404-656-4507
TTY: 711
Website: http://dch.georgia.gov/medicaid

HAWAII
Department of Human Services
MEDQUEST
801 Dillingham Blvd
Honolulu, HI 96817
Toll free: 1-877-628-5076
Local: 1-808-587-3540 or 1-808-524-3370
TTY: 711 or 1-855-585-8604
Website: www.medquest.hawaii.gov

IDAHO
Department of Health and Welfare
PO Box 83720
Boise, ID 83720-0026
Toll free: 1-877-456-1233
Local: 1-208-334-5747
TTY: 711
Website: www.healthandwelfare.idaho.gov

ILLINOIS
Illinois Department of Healthcare and Family Services
Prescott Bloom Building
201 South Grand Avenue, East
Springfield, Il 62763
Toll free: 1-800-226-0768
Local: 1-217-782-1200
TTY: 711
Website: www.illinois.gov/hfs

INDIANA
Indiana Medicaid
402 W Washington Street, Room W-392
P. O. Box 7083
Indianapolis, IN 46204
Toll Free: 1-800-457-4584
Local: 1-317-233-4455
TTY: 711
Website: www.in.gov/medicaid

IOWA
Iowa Medicaid
Department of Human Services
Hoover Building
1305 E Walnut St.
Des Moines, IA 50319
Toll free: 1-800-338-8366
Local: 1-515-256-4606 (Des Moines metro)
TTY: 711 or 1-800-735-2942
Website: http://dhs.iowa.gov/ime/members

KANSAS
KanCare: Medicaid for Kansas
503 S. Kansas Ave.
Topeka, KS 66603-3404
Toll free: 1-800-792-4884
TTY: 711
Website: www.kancare.ks.gov

KENTUCKY
Cabinet for Health and Family Services
275 E. Main Street
Frankfort, KY 40621
Toll free: 1-800-372-2973
Local: 1-502-564-5497
TTY: 1-800-627-4702
Website: www.chfs.ky.gov/dms

LOUISIANA
LA Department of Health
PO Box 629
Baton Rouge, LA 70821-0629
Toll free: 1-888-342-6207 or 1-855-229-6848
Local: 1-225-342-9500
TTY: 711 or 1-855-526-3346
Website: http://ldh.la.gov/index.cfm

MAINE
Office of MaineCare Services
11 State House Station
Augusta, ME 04333-0011
Toll free: 1-800-977-6740
Local: 1-207-287-2674
TTY: 711
Website: www.maine.gov/dhhs/oms

MARYLAND
Maryland Dept. of Health
201 W. Preston Street
Baltimore, MD 21201-2399
Toll free: 1-877-463-3464
Local: 1-410-767-6500
TTY: 711
Website: https://health.maryland.gov

MASSACHUSETTS
Office of Medicaid - MassHealth
1 Ashburton Pl., 11th Floor
Boston, MA 02108
Toll free: 1-800-841-2900
Local: 1-617-573-1770
TTY: 1-800-497-4648
Website: www.mass.gov/masshealth

MICHIGAN
Michigan Department of Health & Human Services
333 S. Grand Ave.
PO Box 30195
Lansing, MI 48909
Toll free: 1-855-275-6424
Local: 1-517-373-3740
TTY: 711 or 1-800-649-3777
Website: www.michigan.gov/mdhhs

MINNESOTA
Department of Human Services
444 Lafayette Rd
St. Paul, MN 55155
Toll free: 1-800-657-3739
Local: 1-651-431-2670 or 1-651-431-2000
TTY: 1-800-627-3529
Website: https://mn.gov/dhs/

MISSISSIPPI
Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201-1399
Toll free: 1-800-421-2408
Local: 1-601-359-6050
TTY: 711 or 1-800-855-1000
Website: www.medicaid.ms.gov

MISSOURI
MO HealthNet Division
615 Howerton Court
PO Box 6500
Jefferson City, MO 65102-6500
Toll free: 1-800-392-2161
Local: 1-573-751-3425
TTY: 1-800-735-2966 or 711
Website: http://dss.mo.gov/mhd

MONTANA
Department of Public Health & Human Services
1400 Broadway St
Helena, MT 59601
Toll free: 1-800-362-8312 or 1-888-706-1535
Local: 1-406-444-4540
TTY: 711 or 1-800-253-4091
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms

NEBRASKA
Department of Health and Human Services
301 Centennial Mall South
PO Box 95026
Lincoln, NE 68509
Toll free: 1-855-632-7633
Local: 1-402-473-7000 or 1-402-471-3121
TTY: 711 or 1-402-471-7256
Website: http://dhhs.ne.gov/medicaid

NEVADA
Department of Health and Human Services
1100 East William St., Suite 102
Carson City, NV 89701
Toll free: 1-877-638-3472
Local: 1-775-684-3600
TTY: 711
Website: https://www.medicaid.nv.gov/

NEW HAMPSHIRE
NH Department of Health & Human Services
Medicaid Program
129 Pleasant Street
Concord, NH 03301
Toll free: 1-800-852-3345, ext. 4344 or 1-844-275-3447
Local: 1-603-271-4344
TTY: 1-800-735-2964
Website: www.dhhs.nh.gov

NEW JERSEY
NJ Department of Human Services
Division of Medical Assistance & Health Services
PO Box 712
Trenton, NJ 08625-0712
Toll free: 1-800-356-1561
TTY: 711
Website: www.nj.gov/humanservices/dmahs

NEW MEXICO
Human Services Department
New Mexico Centennial Care Program
PO Box 2348
Santa Fe, NM 87504-2348
Toll free: 1-888-997-2583
Local: 1-505-827-3100
TTY: 711 or 1-855-227-5485
Website: www.hsd.state.nm.us

NEW YORK
New York State Department of Health
Office of Medicaid Management
Corning Tower, Empire State Plaza
Albany, NY 12237
Toll free: 1-800-541-2831
Local: 1-518-486-9057
TTY: 711
Website: www.health.state.ny.us/health_care/medicaid

NORTH CAROLINA
Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501
Toll free: 1-800-662-7030
Local: 1-919-855-4100
TTY: 711
Website: www.ncdhhs.gov/dma

NORTH DAKOTA
Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250
Toll free: 1-800-755-2604
Local: 1-701-328-2321 or 701-328-7068
TTY: 1-800-366-6888 or 711
Website: www.nd.gov/dhs/services/medicalserv

OHIO
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215
Toll free: 1-800-324-8680 or 1-800-686-1516
TTY: 711
Website: http://medicaid.ohio.gov

OKLAHOMA
Health Care Authority
4345 N Lincoln Boulevard
Oklahoma City, OK 73105
Toll free: 1-800-987-7767 or 1-888-365-3742
Local: 1-405-522-7300
TTY: 711
Website: www.okhca.org

OREGON
Oregon Health Authority
500 Summer Street NE, E-20
Salem, OR 97301-1097
Toll free: 1-800-699-9075 or 1-800-273-0557
Local: 1-503-947-2340
TTY: 711
Website:
http://www.oregon.gov/oha/healthplan/pages/index.aspx

PENNSYLVANIA
Department of Human Services
Office of Medical Assistance Programs
P. O. Box 2675
Harrisburg, PA 17105
Toll free: 1-800-692-7462 or 1-866-550-4355
TTY: 1-800-451-5886
Website:
http://www.dhs.pa.gov/citizens/healthcaremedicalassistance/index.htm

RHODE ISLAND
Department of Human Services
Louis Pasteur Building
57 Howard Avenue
Cranston, RI 02920
Toll free: 1-800-964-6211 or 1-855-840-4774
Local: 1-401-462-3000
TTY: 711 or 1-800-745-5555
Website: www.dhs.ri.gov

SOUTH CAROLINA
Department of Health and Human Services
Healthy Connections Medicaid
PO Box 8206
Columbia, SC 29202-8206
Toll free: 1-888-549-0820
TTY: 711 or 1-888-842-3620
Website: www.scdhhs.gov

SOUTH DAKOTA
Department of Social Services
700 Governors Drive
Pierre, SD 57501
Toll free: 1-800-597-1603
Local: 1-605-773-3495 or 1-605-773-3165
TTY: 711
Website: http://dss.sd.gov/medicaid/

TENNESSEE
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
Toll free: 1-800-342-3145 or 1-855-259-0701
TTY: 711 or 1-877-779-3103
Website: www.tn.gov/tenncare

TEXAS
Health and Human Services
Brown-Heatly Building
4900 N Lamar Boulevard
Austin, TX 78751-2316
Toll free: 1-877-541-7905 or 1-800-252-8263
Local: 1-512-424-6500
TTY: 711 or 1-512-424-6597
Website: https://hhs.texas.gov/services/health/medicaid-chip

UTAH
Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Toll free: 1-800-662-9651
Local: 1-801-538-6155
TTY: 711 or 1-800-346-4128
Website: www.health.utah.gov/medicaid

VERMONT
Green Mountain Care
Department of Vermont Health Access
280 State Drive
Waterbury, VT 05671-1010
Toll free: 1-800-250-8427
Local: 1-802-879-5900
TTY: 711
Website: http://www.greenmountaincare.org/health-plans/medicaid

VIRGINIA
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
Toll free: 1-800-643-2273
Local: 1-804-786-6145 or 1-804-786-7933
TTY: 1-800-343-0634
Website: www.dmas.virginia.gov

WASHINGTON
Washington State Health Care Authority
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501
Toll free: 1-800-562-3022
TTY: 711
Website: www.hca.wa.gov/medicaid

WEST VIRGINIA
Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706
Toll Free: 1-877-716-1212 or 1-800-642-8589
Local: 1-304-558-1700
TTY: 711
Website: www.dhhr.wv.gov/bms

WISCONSIN
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53703
Toll free: 1-800-362-3002
Local: 1-608-266-1865
TTY: 711 or 1-888-701-1251 or 1-800-947-3529
Website: www.dhs.wisconsin.gov/medicaid

WYOMING
Wyoming Department of Health
Wyoming Medicaid
6101 Yellowstone Rd, Suite 210
Cheyenne, WY 82009
Toll free: 1-855-294-2127 or 1-866-571-0944
Local: 1-307-777-7656 or 307-777-7531
TTY: 1-855-329-5204
Website:
http://www.health.wyo.gov/healthcarefin/medicaid/home.html

Exhibit D: State Pharmaceutical Assistance Programs (SPAP)

NOTE: States not listed do not have a Medicare-approved SPAP AIDS/HIV Assistance Programs (ADAP) are listed in Exhibit E.

COLORADO

Bridging the Gap, Colorado (BTGC)
Colorado Dept. of Public Health & Environment
4300 Cherry Creek Dr. South
Denver, CO 80246-1530
Local: 1-303-692-2783 or 1-303-692-2716
TTY: 711
Website: https://q1medicare.com/PartD-SPAP-ColoradoBridgingTheGap-SPAP.php

CONNECTICUT

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE)
P.O. BOX 5011
Hartford, CT 06102
Toll Free: 1-800-423-5026
Local: 1-860-269-2029
TTY: 711
Website: http://www.ct.gov/agingservices/site/default.asp

DELAWARE

Delaware Chronic Renal Disease Program
11-13 North Church Ave.
Milford, DE 19963
Toll free: 1-800-464-4357
Local: 1-302-424-7180
TTY: 711
Website: www.dhss.delaware.gov/dhss/dmma/crdprog.html

IDAHO

Idaho AIDS Drug Assistance Program (IDAGAP)
Department of Health and Welfare
P. O. Box 83720
Boise, ID 83720
Toll free: 1-800-926-2588
Local: 1-208-334-5943 or 1-208-334-5612
TTY: 711
Website: www.healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx

INDIANA

HoosierRx
402 W. Washington St.
Room W374, MS07
Indianapolis, IN 46204
Toll free: 1-866-267-4679
Local: 1-317-234-1381
TTY: 711
Website: www.in.gov/fssa/ompp/2669.htm

MAINE

Maine Low Cost Drugs for the Elderly or Disabled Program
Office of MaineCare Services
242 State Street
Augusta, ME 04333
Toll free: 1-866-796-2463
TTY: 1-800-606-0215
Website: http://www.maine.gov/dhhs/oads/home-support/elderly-physically-disabled/index.html

MARYLAND

Maryland Senior Prescription Drug Assistance Program
Maryland SPDAP, c/o Pool Administrators
628 Hebron Avenue, Suite 100
Glastonbury, CT 06033
Toll free: 1-800-551-5995
TTY: 1-800-877-5156
Website: www.marylandspdap.com

Maryland Kidney Disease Program
201 West Preston Street
Baltimore, MD 21201
Toll Free: 1-800-226-2142
Local: 1-410-767-5006
TTY: 711
Website: www.mdrxprograms.com/kdp.html

MASSACHUSETTS

Massachusetts Prescription Advantage
PO Box 15153
Worcester, MA 01615
Toll free: 1-800-243-4636 Ext: 2
TTY: 1-877-610-0241
Website: http://www.mass.gov/prescription-drug-assistance

MISSOURI
Missouri Rx Plan
PO Box 6500
Jefferson City, MO 65102
Toll free: 1-800-375-1406
TTY: 711 or 1-800-735-2966
Website: https://dss.mo.gov/morx

MONTANA
Montana Big Sky Rx Program
PO Box 202915
Helena, MT 59620
Toll free: 1-866-369-1233
Local: 1-406-444-1233
TTY: 711
Website:http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx

Montana Mental Health Services Plan (MHSP)
PO Box 202905
555 Fuller Ave.
Helena, MT 59620
Toll free: 1-800-866-0328
Local: 1-406-444-3964
TTY: 711
Website:
https://dphhs.mt.gov/amdd/Mentalhealthservices/MHSP

NEVADA
Nevada Senior Rx Program
Department of Health and Human Services
3416 Goni Road, Suite D-132
Carson City, NV 89706
Toll free: 1-866-303-6323
Local: 1-775-687-4210 or 1-775-687-0539
TTY: 711
Website:
http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

Nevada Disability Rx
Department of Health and Human Services
3416 Goni Road, Suite D-132
Carson City, NV 89706
Toll free: 1-866-303-6323
Local: 1-775-687-4210 or 1-775-687-0539
TTY: 711
Website:
http://dhhs.nv.gov/Find_Assistance/Medical_Assistance/

NEW JERSEY
Senior Gold Prescription Discount Program
Department of Health and Senior Services
PO Box 715
Trenton, NJ 08625
Toll free: 1-800-792-9745
TTY: 711
Website:
www.state.nj.us/humanservices/doas/home/seniorgolddetail.html

NJ Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)
PO Box 715
Trenton, NJ 08625
Toll free: 1-800-792-9745
TTY: 711
Website: www.state.nj.us/humanservices/doas/services/paad/

New Jersey Department of Human Services
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625
Toll free: 1-800-356-1561
TTY: 711
Website:
https://www.state.nj.us/humanservices/dmahs/home/index.html

NEW YORK
New York State Elderly Pharmaceutical Insurance Coverage (EPIC)
PO Box 15018
Albany, NY 12212
Toll free: 1-800-332-3742
TTY: 1-800-290-9138
Website: https://www.health.ny.gov/health_care/epic/

NORTH CAROLINA
North Carolina HIV SPAP
1902 Mail Service Center
Raleigh, NC 27699
Toll free: 1-877-466-2232
Local: 1-919-733-7301
TTY: 711
Website: http://epi.publichealth.nc.gov/cd/hiv/hmap.html

PENNSYLVANIA
PACE/PACENET
PO Box 8806
Harrisburg, PA 17105-8806
Toll free: 1-800-225-7223
Local: 1-717-651-3600
TTY: 711 or 1-800-222-9004
Website: https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Department of Public Welfare
Special Pharmaceutical Benefits Program
PO Box 8808
Harrisburg, PA 17105-8808
Toll free: 1-800-922-9384
TTY: 711
Website:http://www.dhs.pa.gov/provider/healthcaremedicalassistance/specialpharmaceuticalbenefitsprogram/index.htm

RHODE ISLAND
Rhode Island Pharmaceutical Assistance for the Elderly
Rhode Island Department of Elderly Affairs
Hazard Building, Second Floor
74 West Road
Cranston, RI 02920
Local: 1-401-462-3000
TTY: 1-401-462-0740
Website: http://www.dea.ri.gov/

TEXAS
Texas Kidney Health Care Program (KHC)
Kidney Health Care Program
Department of State Health Services, MC 1938
PO Box 149347
Austin, TX 78714
Toll free: 1-800-222-3986
Local: 1-512-776-7150
Website: https://www.dshs.texas.gov/transition/chi/

Texas HIV State Pharmacy Assistance Program (SPAP)
DSHS HIV/STD Program
PO Box 149347, MC 1873
Austin, TX 78714
Toll Free: 1-800-255-1090 Ext: 3004
Local: 1-512-533-3000
TTY: 711
Website: https://www.dshs.state.tx.us/hivstd/meds/spap.shtm

VERMONT
VPharm
312 Hurricane Lane, Suite 201
Williston, VT 05495
Toll free: 1-800-250-8427
Local: 1-802-879-5900
TTY: 711
Website: http://www.greenmountaincare.org/perscription

VIRGINIA
Virginia HIV SPAP
HCS Unit, 1st Floor
James Madison Building
109 Governor Street
Richmond, VA 23219
Toll free: 1-855-362-0658
TTY: 711
Website: http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/

WASHINGTON
Washington State Health Insurance Pool
PO Box 1090
Great Bend, KS 67530
Toll free: 1-800-877-5187
TTY: 711
Website: www.wship.org/Default.asp

WISCONSIN
Wisconsin SeniorCare
PO Box 6710
Madison, WI 53716
Toll free: 1-800-657-2038
TTY: 711
Website: www.dhs.wisconsin.gov/seniorcare

Wisconsin Chronic Disease Program (Renal Disease, Cystic Fibrosis & Hemophilia Home Care)
PO Box 6410
Madison, WI 53716
Toll free: 1-800-362-3002 or 1-800-947-9627
TTY: 711
Website:
www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

Exhibit E: AIDS Drug Assistance Programs (ADAP)

ALABAMA
Alabama AIDS Drug Assistance Program
HIV/AIDS Division, Alabama Department of Public Health
The RSA Tower
201 Monroe Street, Suite 1400
Montgomery, AL 36104
Phone: 1-866-574-9964 or 1-800-228-0469
Local: 1-334-206-5364
TTY: 711
Website: www.alabamapublichealth.gov/hiv/adap.html

ALASKA
Alaskan AIDS Assistance Association
1057 W. Fireweed Lane, Suite 102
Anchorage, AK 99503
Toll Free: 1-800-478-AIDS
Local: 1-907-263-2050 (Anchorage)/ 1-907-586-6089 (Juneau)
TTY: 711
Website: www.alaskanaids.org/

ARIZONA
AIDS Drug Assistance Program
Arizona Department of Health Services
150 N. 18th Avenue
Phoenix, AZ 85007
Toll Free: 1-800-334-1540 (in state only)
Local: 1-602-364-3610
TTY: 711
Website: https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/

ARKANSAS
Arkansas Department of Health, ADAP Division
4815 W. Markham St., Slot 33
Little Rock, AR 72205
Toll Free: 1-888-499-6544
Local: 1-501-661-2408
TTY: 711
Website: www.healthy.arkansas.gov/programs

CALIFORNIA
California Department of Public Health, Office of AIDS
PO Box 997426, MS 7700
Sacramento, CA 95899-7426
Toll Free: 1-844-421-7050
Local: 1-916-558-1784
TTY: 1-800-735-2929 or 1-800-735-2922
Website: https://www.cdph.ca.gov/

COLORADO
Colorado Dept. of Public Health & Environment (CDPHE)
Care and Treatment Program ADAP-3800
4300 Cherry Creek Dr. South
Denver, CO 80246-1530
Local: 1-303-692-2716
TTY: 711
Website: https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap

CONNECTICUT
Department of Social Services, Medical Operations
25 Sigourney Street, Unit # 4
Hartford, CT 06106
Toll free: 1-800-233-2503 or 1-800-424-3310
Local: 1-860-424-4903
TTY: 711
Website: https://portal.ct.gov/dss/health-and-home-care/cadap

DELAWARE
Delaware ADAP
Thomas Collins building
540 S. Dupont Highway
Dover, DE 19901
Local: 1-302-744-1050 or 1-302-744-1000
TTY: 711
Website:
http://dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html

DISTRICT OF COLUMBIA
DC AIDS Drug Assistance Program
Department of Health
899 North Capitol Street, NE, 4th Floor
Washington, DC 20002
Toll Free: 1-888-311-7632 / Local: 1-202-671-4815
TTY: 711
Website: www.dchealth.dc.gov/dc-adap

FLORIDA
AIDS Drugs Assistance Program, FL Dept. of Health, HIV/AIDS
4052 Bald Cypress Way
Tallahassee, FL 32399
Toll Free: 1-800-352-2437
Local: 1-850-245-4422
TTY: 1-888-503-7118
Website: www.floridahealth.gov/diseases-and-conditions/aids/adap/

GEORGIA
Georgia AIDS Drug Assistance Program
Department of Public Health, Office of HIV/AIDS
2 Peachtree St., NW, Suite 14-415
Atlanta, GA 30303
Toll Free: 1-800-436-7442 / Local: 1-404-463-0416
TTY: 711
Website: https://dph.georgia.gov/aids-drug-assistance-program-adap-0

HAWAII
HIV Drug Assistance Program (HDAP)
Harm Reduction Services
728 Sunset Avenue
Honolulu, HI 96816
Local: 1-808-733-9360
TTY: 711
Website: http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/

IDAHO
Idaho Ryan White Part B Program (RWPB)
450 W. State Street
P. O. Box 83720
Boise, ID 83720
Local: 1-208-334-5612
TTY: 711
Website:www.healthandwelfare.idaho.gov/Health/HIV.std.hepatitisprograms/hivcare/tabid/391/Default.aspx

ILLINOIS
Illinois ADAP Office
525 West Jefferson Street, First Floor
Springfield, IL 62761
Toll Free: 1-800-825-3518
Local: 1-217-524-5983 or 1-217-782-4977
TTY: 711
Website: http://www.idph.state.il.us/health/aids/adap.htm

INDIANA
Indiana AIDS Drug Assistance Program
Indiana State Department of Health
2 N. Meridian St., Suite 6C
Indianapolis, IN 46204
Toll Free: 1-866-588-4948 Option 1 / Local: 1-317-233-1325
TTY: 711
Website: www.in.gov/isdh/17740.htm

IOWA
Iowa Department of Public Health, ADAP
321 E. 12th Street
Des Moines, IA 50319-0075
Toll Free: 1-866-227-9878 / Local: 1-515-725-2011
TTY: 711 or 1-800-735-2942
Website: http://www.idph.iowa.gov/hivstdhep/hiv/support

KANSAS
The Kansas Ryan White Part B Program
Curtis State Office Building, 1000 SW Jackson, Suite 210
Topeka, KS 66612
Local: 1-785-368-6567 or 1-785-296-6174
TTY: 711
Website: www.kdheks.gov/sti_hiv/ryan_white_care.htm

KENTUCKY
Kentucky AIDS Drug Assistance Program (KADAP)
275 E Main Street, HS2E-C
Frankfort, KY 40621
Toll Free: 1-866-510-0005 or 1-800-420-7431
Local: 1-502-564-6539
TTY: 711
Website:https://chfs.ky.gov/agencies/dph/dehp/hab/pages/services.aspx

LOUISIANA
Louisiana Health Access Program (LA HAP)
1450 Poydras Street, Suite 2136
New Orleans, LA 70112
Local: 1-504-568-7474
TTY: 711
Website: www.lahap.org

MAINE
Ryan White Program Maine
40 State House Station
Augusta ME 04330
Local: 1-207-287-3747
TTY: 711
Website: www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/ryan-white-b.shtml

MARYLAND
Maryland AIDS Drug Assistance Program (MADAP)
500 North Calvert Street, 5th Floor
Baltimore, MD 21202
Toll Free: 1-800-205-6308 / Local: 1-410-767-6535
TTY: 1-800-735-2258
Website:http://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx

MASSACHUSETTS
MA HIV Drug Assistance Program (HDAP)
Community Research Initiative of New England
529 Main Street, Suite 301
Boston, MA 02129
Toll Free: 1-800-228-2714
Local: 1-617-502-1700
TTY: 711
Website: http://crine.org/hdap/

MICHIGAN
Michigan HIV/AIDS Drug Assistance Program (MIDAP)
Michigan Department of Health and Human Services
Division of Health, Wellness and Disease Control
HIV Care Section
109 Michigan Avenue, 9th Floor
Lansing, MI 48913
Toll Free: 1-888-826-6565
TTY: 711
Website: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_70541_70542---,00.html

MINNESOTA
HIV/AIDS Programs
Department of Human Services
PO Box 64972
St. Paul, MN 55164-0972
Toll Free: 1-800-657-3761
Local: 1-651-431-2414 or 1-651-431-2398
TTY: 711 or 1-800-627-3529
Website: http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

MISSISSIPPI
Office of STD/HIV Care and Services Division
570 East Woodrow Wilson
PO Box 1700
Jackson, MS 39215-1700
Toll Free: 1-888-343-7373 / Local: 1-601-362-4879
TTY: 711 or 1-800-243-7889
Website:http://msdh.ms.gov/msdhsite/_static/14,13047,150.html

MISSOURI
Bureau of HIV, STD, and Hepatitis
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570
Local: 1-573-751-6439
TTY: 711
Website:www.health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

MONTANA
AIDS Drug Assistance Program
Cogswell Building, Room C-211
1400 Broadway
Helena, MT 59620
Local: 1-406-444-4744 or 1-406-444-3565
TTY: 711
Website: www.dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx

NEBRASKA
Department of Health and Human Services ADAP
301 Centennial Mall South
Lincoln, NE 68509
Toll Free: 1-800-782-2437 / Local: 1-402-471-2101
TTY: 711
Website: dhhs.ne.gov/Pages/ryan-white.aspx

NEVADA
Office of HIV/AIDS
4126 Technology Way, Suite 200
Carson City, NV 89706-2009
Local: 1-775-684-4200 or 1-775-684-5928
TTY: 711
Website: http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/

NEW HAMPSHIRE
DHHS-NH CARE Program
29 Hazen Drive
Concord, NH 03301
Toll Free: 1-800-852-3345 x4502 / Local: 1-603-271-4502
TTY: 711 or 1-800-735-2964
Website: www.dhhs.nh.gov/dphs/bchs/std/care.htm

NEW JERSEY
New Jersey ADDP Office
PO Box 722
Trenton, NJ 08625-0722
Toll Free: 1-877-613-4533 or 1-800-353-3232
TTY: 711
Website: http://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml

NEW MEXICO
AIDS Drug Assistance Program, HIV Services Program
1190 S. St. Francis Drive, Suite S-1200
Santa Fe, NM 87505
Local: 1-505-476-3628 or 1-505-287-2435
TTY: 711
Website: https://nmhealth.org/about/phd/idb/hats/

NEW YORK
AIDS Drug Assistance Program (ADAP)
HIV Uninsured Care Programs
Empire Station
PO Box 2052
Albany, NY 12220-0052
Toll free: 1-800-542-2437 or 1-844-682-4058
Local: 1-518-459-1641
TTY: 1-518-459-0121
Website:
www.health.ny.gov/diseases/aids/general/resources/adap

NORTH CAROLINA
Division of Public Health
HIV Medication Assistance Program (HMAP)
1902 Mail Service Center
Raleigh, NC 27699
Toll free: 1-877-466-2232 / Local: 1-919-733-9161
TTY: 711
Website: http://epi.publichealth.nc.gov/cd/hiv/hmap.html

NORTH DAKOTA
Ryan White Program Part B
ND Dept. of Public Health, Division of Disease Control
2635 East Main Avenue
Bismarck, ND 58506-5520
Toll Free: 1-800-472-2180 or 1-800-706-3448
Local: 1-701-328-2378
TTY: 711
Website: www.ndhealth.gov/HIV/ryanwhite/

OHIO
Ohio AIDS Drug Assistance Program (ADAP)
HIV Care Services Section
246 North High Street
Columbus, OH 43215
Toll Free: 1-800-777-4775
Local: 1-614-466-3543
Website: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/AIDS-Drug-Assistance-Program

OKLAHOMA
HIV Drug Assistance Program (HDAP)
OK State Dept. of Health, HIV/STD Services Division
1000 N.E. Tenth St., Mail Drop 0308
Oklahoma City, OK 73117-1299
Toll Free: 1-800-522-0203
Local: 1-405-271-4636
Website:www.ok.gov/

OREGON
Oregon CAREAssist Program
800 NE Oregon Street, Suite 1105
Portland, OR 97232
Toll Free: 1-800-805-2313
Local: 1-971-673-0144
TTY: 711
Website:
https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx

PENNSYLVANIA
Pennsylvania Department of Health
Special Pharmaceutical Benefits Program
625 Forster Street
H&W Building, Room 611
Harrisburg, PA 17120
Toll free: 1-800-922-9384
TTY: 711
Website: www.health.pa.gov

RHODE ISLAND
Executive Office of Health & Human Services
Office of HIV/AIDS, Hazard Building
74 West Road, Suite 60
Cranston, RI 02920
Local: 1-401-462-3295 or 1-401-462-3294
TTY: 711
Website:www.eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx

SOUTH CAROLINA
SC ADAP Insurance Assistance Program
3rd Floor, Mills-Jarrett
Box 101106
Columbia, SC 29211
Toll Free: 1-800-856-9954
Local: 1-803-898-0749
TTY: 711
Website:www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/

SOUTH DAKOTA
Ryan White Part B CARE Program
South Dakota Department of Health
615 E. 4th St.
Pierre, SD 57501-1700
Toll Free: 1-800-592-1861 / Local: 1-605-773-3737
TTY: 711
Website: http://doh.sd.gov/diseases/infectious/ryanwhite/

TENNESSEE
Tennessee Department of Health - HIV/STD Program
710 James Robertson Pwy, 4th Floor
Andrew Johnson Tower
Nashville, TN 37243
Toll Free: 1-800-525-2437 / Local: 1-615-741-7500
TTY: 711
Website: https://www.tn.gov/health/health-program-areas/std0/std/ryanwhite.html

TEXAS
The Texas HIV Medication Program (THMP)
Attn: MSJA, MC 1873
PO Box 149347
Austin, TX 78714
Toll Free: 1-800-255-1090 / Local: 1-512-533-3000
TTY: 711 or 1-800-735-2989
Website: http://www.dshs.texas.gov/hivstd/default.shtm

UTAH
Utah Department of Health, Bureau of Epidemiology
288 North, 1460 West
Box 142104
Salt Lake City, UT 84114-2104
Local: 1-801-538-6197
TTY: 711
Website: http://health.utah.gov/epi/treatment/

VERMONT
Vermont Department of Health
Vermont Medication Assistance Program (VMAP)
108 Cherry Street - PO Box 70
Burlington, VT 05402
Toll Free: 1-800-464-4343 ext 4005 / Local: 1-802-951-4005
TTY: 711
Website: http://healthvermont.gov/immunizations-infectious-disease/hiv/care

VIRGINIA
VA Dept. of Health
HCS Unit, 1st Floor
James Madison Building
109 Governor St
Richmond, VA 23219
Toll free: 1-855-362-0658 (Medication Eligibility Hotline) or 1-800-533-4148 / Local: 1-804-864-7964
TTY: 711
Website: http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/

WASHINGTON
Early Intervention Progam (EIP)
Client Services
PO Box 47841
Olympia, WA, 98504
Toll Free: 1-877-376-9316
Local: 1-360-236-3426
TTY: 711
Website:
https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP

WEST VIRGINIA
West Virginia AIDS Drug Assistance Program
Jay Adams HIV Care
350 Capitol St, Room 125
Charleston, WV 25301
Toll Free: 1-800-642-8244
Local: 1-304-558-2195 or 1-304-232-6822
TTY: 711
Website: https://dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx

WISCONSIN
Wisconsin Division of Public Health
Attn: ADAP
PO Box 2659
Madison, WI 53701-2659
Toll Free: 1-800-991-5532
Local: 1-608-267-6875 or 1-608-261-6952
TTY: 711 or 1-800-947-3529
Website: https://www.dhs.wisconsin.gov/hiv/adap.htm

WYOMING
Wyoming Department of Health
Communicable Disease Unit
6101 Yellowstone Rd., Suite 510
Cheyenne, WY 82002
Toll Free: 1-866-571-0944
Local: 1-307-777-5856 or 1-307-777-7529
TTY: 711
Website: https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/

Exhibit F: Advance Directives / Complaints

ALABAMA
Alabama State Board of Medical Examiners
PO Box 946
Montgomery, AL 36101-0946
Toll free: 1-800-227-2606
Local: 1-334-242-4116
Fax: 1-334-242-4155
Website: www.albme.org

ALASKA
Department of Commerce Community and Economic Development
550 W 7th Ave, Suite 1535
Anchorage, AK 99501-3587
Local: 1-907-269-8100 (Anchorage)/1-907-465-2500 (Juneau)
Fax: 1-907-269-8125 (Anchorage)/1-907-465-5442 (Juneau)
Website: https://www.commerce.alaska.gov/web/

ARIZONA
Arizona Medical Board
1740 W Adams St., Suite 4000
Phoenix, AZ 85007
Local: 1-480-551-2700
Toll free: 1-877-255-2212
Fax: 1-480-551-2702
Website: www.azmd.gov

ARKANSAS
Arkansas State Medical Board
1401 West Capitol Avenue, Suite 340
Little Rock, AR 72201-2936
Local: 1-501-296-1802
Fax: 1-501-603-3555
Website: www.armedicalboard.org

CALIFORNIA
Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Toll free: 1-800-633-2322
Local: 1-916-263-2382
Fax: 1-916-263-2435
Website: www.mbc.ca.gov

COLORADO
Department of Regulatory Agencies
Colorado Medical Board
1560 Broadway, Suite 1350
Denver, CO 80202
Toll Free: 1-800-886-7675
Local: 1-303-894-7800 or 1-303-894-7855
Fax: 1-303-894-7692
Website: www.colorado.gov/dora

CONNECTICUT
Department of Public Health, Practitioner Investigations Unit
410 Capitol Ave, MS#12APP, PO Box 340308
Hartford, CT 06134-0308
Toll Free: 1-800-842-0038
Local: 1-860-509-7603
Fax: 1-860-707-1984
Website: https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/

DELAWARE
Division of Professional Regulation
Cannon Building, Suite 203
861 Silver Lake Boulevard
Dover, DE 19904
Local: 1-302-744-4500
Fax: 1-302-739-2711
Website: http://dpr.delaware.gov

DISTRICT OF COLUMBIA
Health Professional Licensing Administration
899 North Capitol Street, NE, 2nd Floor
Washington, DC 20002
Local: 1-202-724-4900
Fax: 1-202-724-5145
Website: https://dchealth.dc.gov/page/health-regulation-and-licensing-administration

FLORIDA
Division of Medical Quality Assurance, Consumer Svcs Unit
Florida Department of Health
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399
Local: 1-850-245-4339
Fax: 1-850-488-0796
Website: www.floridahealth.gov/licensing-and-regulation/enforcement/index.html

GEORGIA
Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, NW, 36th Floor
Atlanta, GA 30303
Local: 1-404-656-3913 or 1-404-657-6494
Fax: 1-404-656-9723
Website: www.medicalboard.georgia.gov

HAWAII
Regulated Industries Complaints Office
Dept. of Commerce & Consumer Affairs
235 South Beretania Street, 9th Floor
Honolulu, HI 96813
Toll Free: 1-800-468-4644
Local: 1-808-587-3222 or 1-808-587-4272
Fax: 1-808-586-2670
Website: http://cca.hawaii.gov/

IDAHO
Idaho Board of Medicine
Logger Creek Plaza
345 Bobwhite Ct, Suite 150
Boise, ID 83706
Local: 1-208-327-7000
Fax: 1-208-327-7005
Website: https://bom.idaho.gov/BOMPortal/Home.aspx

ILLINOIS
Department of Financial & Professional Regulation
Division of Professional Regulation
Complaint Intake Unit
100 West Randolph Street, Suite 9-300
Chicago, IL 60601
Toll free: 1-888-473-4858
Local: 1-312-814-6910
Fax: 1-312-814-5392
TTY: 1-866-325-4949
Website: www.idfpr.com

INDIANA
Consumer Protection Division
Office of the Indiana Attorney General
302 W. Washington Street, 5th Floor
Indianapolis, IN 46204
Toll free: 1-800-382-5516
Local: 1-317-232-6330
Website: www.in.gov/attorneygeneral

IOWA
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686
Local: 1-515-242-3252 or 1-515-281-6641
Fax: 1-515-242-5908
Website: http://medicalboard.iowa.gov

KANSAS
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612
Toll free: 1-888-886-7205
Local: 1-785-296-7413
Fax: 1-785-368-7102
TTY: 711 or 1-800-766-3777
Website: www.ksbha.org

KENTUCKY
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
Local: 1-502-429-7150
Fax: 1-502-429-7158
Website: http://kbml.ky.gov

LOUISIANA
Louisiana State Board of Medical Examiners
630 Camp Street
New Orleans, LA 70130
Local: 1-504-568-6820
Fax: 1-504-568-8893
Website: www.lsbme.la.gov

MAINE
Division of Licensing and Certification
Maine Department of Health and Human Services
State House Station #11
41 Anthony Avenue
Augusta, ME 04333
Toll Free: 1-800-791-4080
Local: 1-207-287-9300
TTY: 711
Website: www.maine.gov/dhhs/dlrs

MARYLAND
Maryland Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215
Toll Free: 1-800-492-6836
Local: 1-410-764-4777
Fax: 1-410-358-2252 or 410-358-1298
TDD: 1-800-735-2258
Website: www.mbp.state.md.us

MASSACHUSETTS
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Toll free: 1-800-377-0550
Local: 1-781-876-8200
Fax: 1-781-876-8383
TTY: 1-781-876-8395
Website: www.mass.gov/orgs/board-of-registration-in-medicine

MICHIGAN
Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
611 W. Ottawa Street – Ottawa Building
PO Box 30004
Lansing, MI 48909
Toll free: 1-800-882-6006
Local: 1-517-373-9196 or 1-517-335-1980
Fax: 1-517-335-7167 or 1-517-241-3354
Website: www.michigan.gov/lara

MINNESOTA
Minnesota Board of Medical Practice
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414
Toll free: 1-800-657-3709
Local: 1-612-617-2130
Fax: 1-612-617-2166
TTY/TDD: 1-800-627-3529
Website: www.bmp.state.mn.us

MISSISSIPPI
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216
Local: 1-601-987-3079
Fax: 1-601-987-4159
Website: https://www.msbml.ms.gov/

MISSOURI
Board of Registration for the Healing Arts
3605 Missouri Boulevard
PO Box 4
Jefferson City, MO 65102
Local: 1-573-751-0098
TTY: 1-800-735-2966
Fax: 1-573-751-3166
Website: http://pr.mo.gov/healingarts.asp

MONTANA
Montana Department of Labor & Industry
Business Standards Division
301 South Park, 4th Floor
PO Box 200514
Helena, MT 59620-0514
Local: 1-406-841-2333 or 1-406-841-2362
Fax: 1-406-841-2363
Web Site: http://boards.bsd.dli.mt.gov/med

NEBRASKA
DHHS, Division of Public Health Investigations
1033 O Street, Suite 500
Lincoln, NE 68508
Local: 1-402-471-0175
Fax: 1-402-471-6238 or 1-402-742-8335
Web Site: http://dhhs.ne.gov/Pages/investigations.aspx

NEVADA
Nevada State Board of Medical Examiners
9600 Gateway Dr.
Reno, NV 89521
Local: 1-775-688-2559
Toll free: 1-888-890-8210
Fax: 1-775-688-2321
Web Site: www.medboard.nv.gov

NEW HAMPSHIRE
New Hampshire Board of Medicine
Office of Professional Licensure and Certification
121 South Fruit Street, Suite 301
Concord, NH 03301
Toll Free: 1-800-780-4757
Local: 1-603-271-1203 or 1-603-271-6930
Fax: 1-603-271-6702
Website: https://www.oplc.nh.gov/medicine/

NEW JERSEY
New Jersey State Board of Medical Examiners
140 East Front Street, 3rd Floor
Trenton, NJ 08608
Local: 1-609-826-7100
Fax: 1-609-826-7117
Web Site: http://www.njconsumeraffairs.gov/bme/

NEW MEXICO
New Mexico Medical Board
2055 So. Pacheco Street, Building 400
Santa Fe, NM 87505
Toll free: 1-800-945-5845
Local: 1-505-476-7220
Fax: 1-505-476-7237
Web Site: www.nmmb.state.nm.us

NEW YORK
Office of Professional Medical Conduct
NYS Department of Health
Riverview Center
150 Broadway, Suite 355
Albany, NY 12204-7219
Toll free: 1-800-663-6114
Local: 1-518-402-0836 or 1-518-402-0855
Fax: 1-518-402-0866
Web Site:
https://www.health.ny.gov/professionals/doctors/conduct/

NORTH CAROLINA
North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619
Toll free: 1-800-253-9653
Local: 1-919-326-1109 or 1-919-326-1100
Fax: 1-919-326-1131
Web Site: www.ncmedboard.org

NORTH DAKOTA
North Dakota Board of Medicine
418 E. Broadway Avenue, Suite 12
Bismarck, ND 58501
Local: 1-701-328-6500
Fax: 1-701-328-6505
Web Site: www.ndbom.org

OHIO
State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, OH 43215
Local: 1-614-466-3934
Fax: 1-614-728-5946
Web Site: www.med.ohio.gov

OKLAHOMA
State Board of Medical Licensure and Supervision
101 NE 51st St.
Oklahoma City, OK 73105
Toll free: 1-800-381-4519
Local: 1-405-962-1400 ext. 120
Fax: 1-405-962-1440
Web Site: www.okmedicalboard.org

OREGON
Oregon Medical Board
1500 SW 1st Ave., Suite 620
Portland, OR 97201-5847
Toll free: 1-877-254-6263
Local: 1-971-673-2700
Fax: 1-971-673-2670
Website: www.oregon.gov/omb

PENNSYLVANIA
Pennsylvania State Board
Department of State
2601 North Third Street
PO Box 2649
Harrisburg, PA 17105-2649
Toll free: 1-800-822-2113
Local: 1-717-783-4858 or 1-717-787-2381
Fax: 1-717-705-2882 or 1-717-787-7769
Website: http://www.dos.pa.gov/ProfessionalLicensing/

RHODE ISLAND
Rhode Island Department of Health
Complaint Unit-Room 105A
3 Capitol Hill
Providence, RI 02908
Local: 1-401-222-5200
Fax: 1-401-222-2158
TTY: 711
Web Site: www.health.ri.gov/complaints

SOUTH CAROLINA
Board of Medical Examiners
110 Centerview Drive, Suite 202
Columbia, SC 29210-8432
Local: 1-803-896-4300 or 1-803-896-4470
Fax: 1-803-896-4656 or 1-803-896-7680
Web Site: https://www.llr.sc.gov/pol/medical/

SOUTH DAKOTA
Board of Medical and Osteopathic Examiners
101 N Main Avenue, Suite 301
Sioux Falls, SD 57104
Local: 1-605-367-7781
Fax: 1-605-367-7786
Web Site: www.sdbmoe.gov

TENNESSEE
Department of Health - Office of Investigations
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
Toll free: 1-800-852-2187
Local: 1-615-532-4384 or 1-615-532-3421
Fax: 1-615-532-2499
Web Site: https://www.tn.gov/health/health-program-areas/health-professional-boards/report-a-concern.html

TEXAS
Medical Board Investigations Department
PO Box 2018, MC-263
Austin, TX 78768
Toll free: 1-800-248-4062 or 1-800-201-9353
Local: 1-512-305-7030 or 1-512-305-7010
Fax: 1-512-305-7051
Web Site: www.tmb.state.tx.us/page/consumer

UTAH
Division of Occupation and Professional Licensing
PO Box 146741
Salt Lake City, UT 84111-6741
Toll free (in-state only): 1-866-275-3675
Local: 1-801-530-6628 or 1-801-530-6630
Fax: 1-801-530-6511
Website: www.dopl.utah.gov/

VERMONT
Department of Health - Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
Toll free: 1-800-745-7371 / Local: 1-802-657-4220
Fax: 1-802-657-4227
Website: www.healthvermont.gov/

VIRGINIA
Department of Health Professions – Board of Medicine
Perimeter Center
9960 Maryland Drive, Suite 300
Henrico, VA 23233-1463
Toll free: 1-800-533-1560
Local: 1-804-367-4691 or 1-804-367-4400
Fax: 1-804-527-4424
Web Site: www.dhp.virginia.gov

WASHINGTON
Health Systems Quality Assurance
P.O. Box 47877
Olympia, WA 98504-7877
Toll Free: 1-800-525-0127
Local: 1-360-236-4700 or 1-360-236-2620
Fax: 1-360-236-2626 or 1-360-236-4818
TTY: 711
Website: www.doh.wa.gov/hsqa

WEST VIRGINIA
Board of Medicine Complaint Committee
101 Dee Drive, Suite 103
Charleston, WV 25311
Local: 1-304-558-2921 Extention 70008
Fax: 1-304-558-2084
Web Site: www.wvbom.wv.gov

WISCONSIN
Wisconsin Department of Safety and Professional Services
PO Box 7190
Madison, WI 53707-7190
Toll free: 1-877-617-1565
Local: 1-608-266-2112
Fax: 1-608-266-2264
Web Site: www.dsps.wi.gov

WYOMING
Wyoming Board of Medicine
130 Hobbs Ave., Suite A
Cheyenne, WY 82002
Toll free (in-state only): 1-800-438-5784
Local: 1-307-778-7053
Fax: 1-307-778-2069
Web Site: wyomedboard.wyo.gov

VibrantRx™
Prescription Drug Plan

VibrantRx Member Services

Method	Member Services – Contact Information
CALL	1-844-826-3451 Calls to this number are free. We are open 24 hours a day, 365 days a year. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open 24 hours a day, 365 days a year.
WRITE	VibrantRx PO Box 509097 San Diego, CA 92150
WEBSITE	www.MyVibrantRx.com/OGB