Health Plan

2025 CU Health Plan – Medicare

Medical Benefits Book

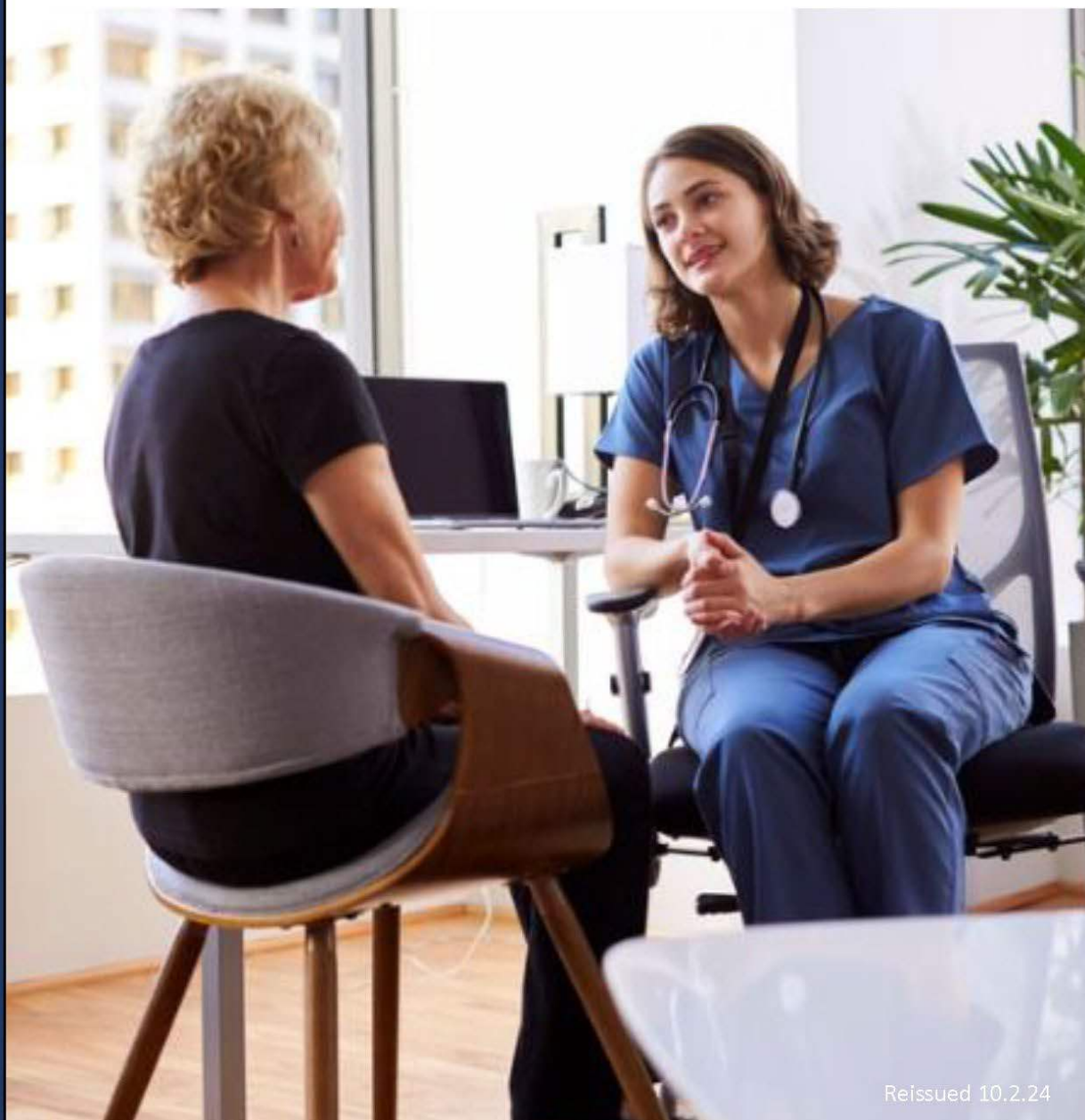
Pharmacy Benefits Book

Funded by the University of Colorado Health and Welfare Trust

Health Plan
Medicare

A guide to your benefits

January 2025-December 2025



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Benefit Booklet
Section 1. Federal Notices

The University of Colorado, as Plan Sponsor of the University of Colorado Health and Welfare Plan ("the University"), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University provides free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The University also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the HIPAA Privacy Officer with CU Health Plan Administration.

If you believe that the University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

HIPAA Privacy Officer
CU Health Plan Administration
1800 Grant Street, Suite 620
Denver, CO 80203
(303) 860-4199
(303) 860-4177 (fax)
cuhealthplan@cu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HIPAA Privacy Officer with CU Health Plan Administration is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician / Provider

We generally allow the designation of a Primary Care Physician / Provider (PCP). You have the right to designate any PCP who participates in the Claim Administrator's network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the Member Services telephone Member Services telephone number on the back of your Identification Card or refer to the Claim Administrator's website, www.anthem.com/cuhealthplan. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need referral from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claim Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Member Services telephone Member Services telephone number on the back of your Identification Card or refer to the Claim Administrator's website, www.anthem.com/cuhealthplan.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call us at the Member Services telephone number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child (ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child (ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on Mental Health or Substance Use Disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Employer.

Section 2.

Section 3. Welcome

Thank you for selecting the CU Health Plan as your insurance provider. By choosing this plan, you're backed by a team dedicated to providing you with the best health coverage possible and helping you save money at a time when healthcare costs are rising. You're committed to your personal wellness, and so are we.

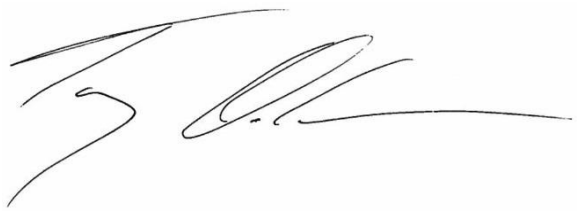
If you're reading this, you're probably looking for information on how your plan works. You have enrolled in a health benefit plan that, pursuant to the terms of this booklet, pays for many of your healthcare expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care. This plan is self-funded by the University of Colorado Health and Welfare Trust. That means all of the claims you make will be paid by the Trust, which is funded by contributions from you and other subscribers at the University of Colorado and CU Medicine. Anthem BlueCross and Blue Shield/HMO Colorado (Anthem) provides administrative services for your medical benefits, including provider network contracting, member services, care management, and other administrative services. Your prescription drug benefits are administered by SilverScript (CVS Caremark).

This booklet is a guide to your plan. Please review this document, as well as the summary of benefits on the Be Colorado website, to become familiar with your benefits, including their limitations and exclusions. Bookmark this document for quick reference when you need it. By learning how your coverage works, you'll be able to make the best healthcare decisions possible and take advantage of all the great benefits available to you.

For questions about medical coverage or how medical benefits are administered, please visit becolorado.org or call Anthem's Member Services department. Anthem's toll-free Member Services department number is located on your Anthem Health Benefit ID Card. For questions about prescription coverage or how prescription benefits are administered please visit www.caremark.com or call the Member Services telephone number on the back of your SilverScript (CVS Caremark).ID card. Thank you for selecting the CU Health Plan for your healthcare needs. We wish you good health.

Important Note

This is not a Medicare Supplement policy. If you are eligible for Medicare, please review the "Guide To Health Insurance for People With Medicare" available at www.medicare.gov or from Medicare.



Tony DeCrosta
Chief Plan Administrator
University of Colorado Health and Welfare Trust

Health Plan

Section 4. Table of Contents

Section 5. Eligibility

The Subscriber is a Member in whose name the membership is established.

- To qualify for benefits, you must:
- Be a resident of the United States.
- Be a retired non-PERA faculty employee.
- Be a retired non-PERA exempt professional employee.
- Be a retired University of Colorado officer in PERA who was a subscriber on July 1, 2009.
- Be eligible and enrolled under Medicare Parts A and B.

In addition, only your Medicare eligible Dependents will be eligible for benefits under this Booklet.

Dependents

A Subscriber's Medicare Eligible Dependents may include the following:

- **Legal Spouse/Partner.** As defined by your employer.
- **Dependent child**. A Subscriber's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Subscriber for legal adoption, or a child for whom the Subscriber has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Subscriber when enrolling his or her child or a partner's child through the calendar month in which the child turns age 27. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Please contact your employer for more information.
- **Disabled Dependent child**. An unmarried child who is 27 years of age or older, medically certified as disabled and dependent upon the parent may be covered under the terms of this Benefits Booklet. The employer must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 27.
- **Grandchild**. A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for benefits unless the Subscriber or the Subscriber's Spouse is court-appointed as having parental responsibility for the grandchild or has adopted the grandchild. The Subscriber must submit a Benefits Enrollment/Change Form or online submission and evidence of court appointment as having parental responsibility or documents evidencing a legal adoption.

Enrollment Process

For eligible Subscribers and their Medicare eligible Dependents to participate in the Plan, the Subscriber must follow his/her employer's enrollment process, which details who is eligible and which applicable forms or online submission are required for enrollment. Eligibility for benefits under this Booklet begins as of the Effective Date as indicated in the employer's files. Services received before that date are not covered.

Note: Submission of a Benefits Enrollment/Change Form or online submission does not guarantee your enrollment.

You need to contact your employer for details regarding required documentation for adding Spouse/Partners and their dependents using the contacts below:

- University of Colorado – Employee Services
- University of Colorado Medicine – Human Resources

Section 6. How to Access Your Services and Obtain Approval of Benefits

Benefits under this Booklet will be the Medicare allowed amount for those services covered by Medicare up to Our Maximum Allowed Amount. Medicare is the primary payer for this Plan, and Covered Services payable under this Plan will be reduced by the amounts payable for the same expenses under Medicare Parts A and B. Members enrolled under this Booklet will be considered enrolled under Medicare Parts A and B. If the medical service or supply is not covered under Medicare then it is not a covered benefit under this Plan unless otherwise indicated.

Any preauthorization requirements will be determined by Medicare unless a service is not covered by Medicare and is covered under this Booklet. In those situations preauthorization may be required.

Preauthorization is a process We use to ensure that your care is provided in the most medically appropriate setting. The Preauthorization process may set limits on the coverage available under this Booklet. Preauthorization is required before a Hospital admission or before receiving certain procedures or services. Some drugs also require Preauthorization.

Admissions for all inpatient stays and certain outpatient procedures require Preauthorization. Your Provider must call the number for Provider Authorization on your Health Benefit ID Card to request Preauthorization. We will review the request for Preauthorization. If the inpatient stay or outpatient procedure is approved, all benefits available under the member's Booklet are provided. We initially authorize a specified number of days for the inpatient stay and reevaluate such Authorization if additional days are requested by the Provider. This process facilitates your timely discharge or transfer to the appropriate level of care.

Contracted Providers will bill Us directly and accept Our Maximum Allowed Amount as payment in full. The Maximum Allowed Amount is the dollar amount approved by Us for a specific covered service. For those services not covered by Medicare but that are covered under this Booklet, you are responsible for determining if your Provider is a contracted Provider.

We may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this benefit plan's members.

Benefit Maximum

Some Covered Services have a maximum number of days, visits or dollar amounts that we will allow during a Benefit Period. When the Deductible (if applicable) is applied to a Covered Service which has a maximum number of days or visits, the Benefit Maximum may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by us.
Even after you satisfy the Out-of-Pocket Annual Maximum, our reimbursement remains limited by the Benefit Maximums of this plan.

If you leave this Plan, and go on to a new Plan with us in the same Benefit Period, Covered Services that have a Benefit Maximum will be carried over to the new Plan. For example, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new Plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard", which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Procedure (How to File a Claims)" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Fees for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, they must pay for the actual cost of the services.

Section 7. Benefits/Coverage (What is Covered)

Any benefits payable under this Booklet for you and your Medicare eligible Dependent will be reduced by the amounts payable for the same expense under Medicare Parts A and/or B. This means Medicare will pay their benefits first and will be the primary payer of benefits. Covered Services and supplies are only benefits if they are Medically Necessary or preventive, not otherwise excluded under this Booklet as determined by Us in administering the Plan, and obtained in the manner required by this Booklet. Benefit limits and maximums can be found on the Summary of Benefits and Coverage at https://www.anthem.com/mcr/cuhealthplan.

All benefits are subject to Medicare allowable covered guidelines which are described below. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment by Us.

If Medicare covers the service or supply the allowance will be determined by Medicare. If the provider accepts Medicare assignment, you are not responsible for any amounts that are more the allowance Medicare allows. If Medicare does not cover a service or supply, then it is not a covered service except as provided below and it is subject to the terms of this Booklet.

Acupuncture/Nerve Pathway Therapy

Please see “Therapy Services” later in this section.

Ambulance Services

If Medicare does not cover a service or supply, then it is not a covered service.

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following are met:

- For ground ambulance, you are taken:
- From your home, the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
- Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
- Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In- Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available. You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Behavioral Health Services

Please see "Mental Health and Substance Use Disorder Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractic Care

Please see "Therapy Services" later in this section.

Clinical Trials

If Medicare does not cover a service or supply, then it is not a covered service.

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    i. The Department of Veterans Affairs.
    ii. The Department of Defense.
    iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service; or

ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

If Medicare does not cover a service or supply, then it is not a covered service.

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Cleft Palate and Cleft Lip Conditions

Benefits are available for inpatient care and outpatient care, including:

- Orofacial surgery
- Surgical care and follow-up care by plastic surgeons and oral surgeons
- Orthodontics and prosthodontic treatment
- Prosthetic treatment such as obturators, speech appliances, and prosthodontic
- Prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip

If you have a dental plan, the dental plan would be the main plan and must fully cover orthodontics and dental care for cleft palate and cleft lip conditions.

Dental Anesthesia for Children

Benefits are available for general anesthesia from a Hospital, outpatient surgical Facility or other Facility, and for the Hospital or Facility charges needed for dental care for a covered Dependent child who:

- Has a physical, mental or medically compromising condition; or
- Has dental needs for which local anesthesia is not effective because of acute infection, anatomic variation or allergy; or
- Is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or
- Has sustained extensive orofacial and dental trauma.

Other

The only other Covered Services are Facility charges for inpatient and/or outpatient care but do not include charges for the dental services. Benefits are payable in such settings are Medically Necessary for the Member’s health problem or the dental treatment calls for it to keep you safe.

Diabetes Equipment, Education, and Supplies

If Medicare does not cover a service or supply, then it is not a covered service.

Your Plan covers diabetes training and medical nutrition therapy if you have diabetes (whether or not it is insulin dependent), or if you have raised blood glucose levels caused by pregnancy. Other medical conditions may also qualify. But the services need to be ordered by a Doctor and given by a Provider who is certified, registered or with training in diabetes. Diabetes training sessions must be provided by a Provider in an outpatient Facility or in a Doctor’s office.

Screenings for gestational diabetes are covered under “Preventive Care” later in this section.

Diagnostic Services

If Medicare does not cover a service or supply, then it is not a covered service.

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by us.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Audiological testing to measure the level of hearing loss and to choose the proper make and model of a hearing aid. Hearing tests related to an exam for prescribing or fitting of a hearing aid.
- Tests ordered before a surgery or admission

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

Please see “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

If Medicare does not cover a service or supply, then it is not a covered service.

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Custom foot orthotics, orthopedic shoes or footwear or support items are also covered.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are required to adequately meet your needs.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

1) Artificial limbs and accessories. For prosthetic arms and legs we cover up to the benefits amounts provide by federal laws for Medicare or where needed to meet applicable health insurance laws;
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes, or when needed to replace human lenses absent at birth, or due to ocular injury, or for the treatment of keratoconus or aphakia;
3) Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act;
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
5) Restoration prosthesis (composite facial prosthesis);
6) The first wig needed after cancer treatment;
7) Cochlear implants.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, diabetic supplies, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Services

If Medicare does not cover a service or supply, then it is not a covered service.

Services provided for conditions that do not meet the definition of Emergency will not be covered.

Emergency (Emergency Medical Condition)

“Emergency,” or “Emergency Medical Condition” means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing
the patient’s health or the health of another person in serious danger or, for a pregnant woman, placing the woman’s health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

“Emergency Care” means a medical or behavioral health exam within the capability of the Emergency Department of a Hospital or freestanding Emergency Facility, and includes ancillary services routinely available in the Emergency Department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

With respect to an Emergency, stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a Facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, and will not require Precertification.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See “How to Access Your Services and Obtain Approval of Benefits

(Applicable to managed care plans)" for more details.

Treatment you get after your condition has stabilized is not Emergency Care.

Home Health Care Services

If Medicare does not cover a service or supply, then it is not a covered service.

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. Home Health Care is covered only when such care is necessary as an alternative to Hospital stay. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Prior Hospital stay is not required. Home Health Care must be prescribed by a Doctor, under a plan of care established by the Doctor in collaboration with a Home Health Care Agency. We must preauthorize all care and reserve the right to review treatment plans at periodic intervals.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services of physical, occupational, speech and language, respiratory and inhalation (except for Chiropractic Care / Manipulative Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment, prosthetics and orthopedic appliances
- Private duty nursing services in the home

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Use Disorder Services" section below.

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the "Inpatient Services" section below.

Hospice Care

If Medicare does not cover a service or supply, then it is not a covered service.

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Hospice care includes routine home care, constant home care, inpatient Hospice and inpatient respite. Covered Services

include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Doctor services and diagnostic testing.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes and nutritional counseling.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Prosthetics and orthopedic appliances.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties for one year after the Member's death.
- Transportation.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan. Any care you get that has to do with an unrelated illness or medical condition will be subject to the provisions of this plan that deals with that illness.

Infertility Services

Please see "Maternity and Reproductive Health Services" later in this section.

Inpatient Services

If Medicare does not cover a service or supply, then it is not a covered service.

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.

- Newborn care for during and after the mother's maternity Hospital stay for treatment of injury and sickness and medically diagnosed Congenital Defects and Birth Abnormalities.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services

include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

*When available in your area, certain Providers have programs available that may allow you to receive Inpatient Services in your home instead of staying in a Hospital. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under "Home Health Care Services." Your Provider will contact you if you are eligible, and provide you with details on how to enroll. If you choose to participate, the cost shares listed in your Schedule of Benefits under "Inpatient Services" will apply.

Maternity and Reproductive Health Services

If Medicare does not cover a service or supply, then it is not a covered service.

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy, Complications of Pregnancy, and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including

circumcision of a covered male Dependent;

- Prenatal, postnatal and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). If the baby is born between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning after the 48 or 96 hours timeframe. However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C- section.

Contraceptive Benefits

Benefits include injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Doctor, performed to save the life or health of the mother, or as a result of incest or rape.

Infertility Diagnostic Services

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. As part of other Covered Services under this Plan, benefits may also include services to treat the underlying medical conditions that may be associated with involuntary infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Infertility Services

Members, with or without a diagnosis of infertility, in need of medical services to achieve pregnancy can access the fertility benefit through WIN Fertility, even if services are not covered by Medicare. Prior authorization by the WIN Fertility's Medical Management is required prior to initiation of medical treatment for family building. Failure to attain preauthorization of services for each service will result in a denial of benefits. Coverage is subject to available benefit at time of claim submission. Out of pocket cost shares may be applicable.

Covered Services include:

- Up to three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the ASRM, using single embryo transfer when recommended and medically appropriate; and

- Standard fertility preservation services, for a member who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility. Standard fertility preservation services means procedures and services that are consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology (ASCO), the ASRM or their respective successor organizations.

Exclusions: The following services are not covered:

a. If a member has undergone an elective sterilization procedure, they are not eligible for benefits unless they undergo a successful reversal; Or WIN Fertility's consulting medical director determines that the reversal of the elective sterilization procedure is not medically indicated or will not improve the likelihood of conception due to multifactorial causes of infertility. Reversal of a sterilization procedure is not covered. HOWEVER, the partner that did not elect voluntary sterilization could be eligible for benefits based on plan design.

b. Experimental or Investigational medical and surgical procedures.

c. Services which are not medically appropriate.

d. Expenses for Surrogacy and fees associated with surrogacy.

e. Expenses for procuring Donated Oocytes or Sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications

f. Services which are not listed as covered in this benefit.

For more information contact WIN Fertility:

866-430-6068, https://managed.winfertility.com/cuhealthplan/, WIN Fertility app code CUHP22

Mental Health and Substance Use Disorder Services

If Medicare does not cover a service or supply, then it is not a covered service.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a physician weekly or more often,
  - Rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In- Home Behavioral Health Services.
- **Online Visits** when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice or other platform approved by us. Online visits generally do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, Plan coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit Precertification, or Doctor to Doctor discussions. Online visits are not the same as Telehealth Services and can, at times, include audio-only interactions but generally do not include store-and-forward transfers.

Note: No Member will be denied coverage for medical, surgical, or behavioral, mental, or Substance Use Disorder services as a result of self-harm or suicide attempt or completion.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any Provider licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

If Medicare does not cover a service or supply, then it is not a covered service.

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor and Primary Care Provider visits in the home are different than the “Home Health Care Services” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice or other platform approved by us. Online visits generally do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, Plan coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit Precertification, or Doctor to Doctor discussions. Online visits are not the same as Telehealth Services and can, at times, include audio-only interactions but generally do not include store-and-forward transfers. For Mental Health and Substance Use Disorder Online Visits, see the “Mental Health and Substance Use Disorder Services” section.

Prescription Drugs Administered in the Office See the section “Prescription Drugs Administered by a Medical Provider” for more details.

Orthotics

Please see “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

If Medicare does not cover a service or supply, then it is not a covered service.

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

If Medicare does not cover a service or supply, then it is not a covered service.

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1) Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer,

        This includes the preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography)
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity.

Tobacco use screening and tobacco cessation counseling and intervention is also covered.

2) Immunizations for children, adolescents, and adults, including cervical cancer vaccinations for females, where recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3) Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

4) Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

   a. Women's contraceptives, sterilization treatments, and counseling. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered.

   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

   c. Gestational diabetes screening.

5) Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including counseling. FDA-approved preexposure prophylaxis (PrEP), related services and monitoring including follow-up HIV testing and additional testing to monitor the effects of the PrEP medications.

Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites: https://www.healthcare.gov/what-are-my-preventive- care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

In addition to federal and state law rules, Covered Services also include:

1) Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider.

2) Flu shot from a flu shot clinic. Coverage is provided for one flu shot per Benefit Period, or more often as we decide. To learn more about flu shot clinics, how much we reimburse you for a flu shot, and to get the claim form, visit our website at www.anthem.com/cuhealthplan. You may also call Member Services. The amount we cover is subject to change. A flu shot paid for in full, or in part by someone else, is not eligible for coverage.

Preventive Care for Chronic Conditions (per IRS guidelines)

If Medicare does not cover a service or supply, then it is not a covered service.

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as "the agencies"). Details on those guidelines can be found on the IRS's website at the following link:

https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain- care-for-chronic-conditions

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

Please see “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

If Medicare does not cover a service or supply, then it is not a covered service.

When you require Inpatient skilled nursing and related services for convalescent, rehabilitative or habilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility, or is otherwise licensed to provide the services. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

If Medicare does not cover a service or supply, then it is not a covered service.

Your Plan covers surgical services on an Inpatient or outpatient basis. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

When due to breast cancer, reconstructive and surgical coverage will be provided in a manner determined in consultation with the attending Physician and the Member. Members will have to pay

the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Therapy Services

If Medicare does not cover a service or supply, then it is not a covered service.

Physical Medicine Therapy Services

For children under age 6, your Plan covers at least 20 visits, each, of physical, speech and occupational therapy. Benefits include the treatment of Congenital Defects and Birth Abnormalities, even if it is a long term condition. It also doesn't matter if the reason for the therapy is to maintain (not improve) the child's skills. For children between 3 and 6 with Autism Spectrum Disorders, We cover more than 20 visits of each therapy if part of a Member's Autism Treatment Plan and determined Medically Necessary by us.

From the Members birth until the Member's third (3rd) birthday, these services shall be provided only where and only to the extent required by applicable law.

For age 6 and older, your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time.

Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment. For a cleft palate or cleft lip, Medically Necessary speech therapy is not limited, but those visits lower the number of speech therapy visits available to treat other problems.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic Care /Osteopathic / Manipulative therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but Chiropractic Care / Manipulative Therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. Chiropractic benefits are Covered Services limited to office visits for evaluation, manual manipulation of the spine, laboratory services, X-ray of the spine and certain physical modalities and procedures for musculoskeletal disorders.
- **Acupuncture/Nerve Pathway therapy** – Treatment of neuromusculoskeletal pain by a Provider who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Other Therapy Services

If Medicare does not cover a service or supply, then it is not a covered service.

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.

- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy** – Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho- pulmonary drainage and breathing exercises.

Urgent Care Services

If Medicare does not cover a service or supply, then it is not a covered service.

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Urgent Care you get from an Out-of-Network Provider will be covered as an In-Network service, you will not need to pay more than what you would have if you had seen an In-Network Provider.

Section 8. Limitations/Exclusions (What is Not Covered)

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) **Abortions** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies. This includes, but is not limited to:

   a. Holistic medicine,

   b. Acupressure to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, except as specifically listed as a Covered Service in this Plan,

   c. Homeopathic medicine,

   d. Hypnosis,

   e. Aroma therapy,

   f. Reiki therapy,

   g. Herbal, vitamin or dietary products or therapies,

   h. Naturopathy,

   i. Thermography,

   j. Orthomolecular therapy,

   k. Contact reflex analysis,

   l. Bioenergial synchronization technique (BEST),

   m. Iridology-study of the iris,

   n. Auditory integration therapy (AIT),

   o. Colonic irrigation,

   p. Magnetic innervation therapy,

   q. Electromagnetic therapy,

   r. Neurofeedback / Biofeedback.

5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) for all indications unless otherwise required by law.

6) **Autopsies** Autopsies and post-mortem testing.

7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

8) **Breast Reduction Surgery** (reduction mammoplasty) or services related to it, except as required by law or as medically necessary based on Anthem's medical policy.

9) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet.

10) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

11) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

12) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

13) **Complications of/or Services Related to Non-Covered Services** Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

14) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts) unless required by law. This exclusion does not apply to Medically Necessary gender affirming health services.

15) **Court Ordered Testing** Court ordered testing or care unless the testing or care is Medically Necessary and otherwise a Covered Service under this Booklet.

16) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

17) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

18) **Dental Devices for Snoring** Oral appliances for snoring.

19) **Dental Treatment** Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

This Exclusion does not apply to services that we must cover by law.

29) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes, except as listed in this Booklet. This includes, but is not limited to boarding schools and/or

the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

30) **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, or dental caries/cavity in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

31) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

32) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

33) **Eye Exercises** Orthoptics and vision therapy.

34) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

35) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

36) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to care for flat feet, subluxations, cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

37) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

38) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

39) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

40) **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

41) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease

height or alter the rate of growth.

42) **Hearing aids.**

43) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

44) Home Health Care

a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

b) Food, housing, homemaker services and home delivered meals.

49) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

50) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

51) **Infertility Treatment** Infertility procedures not specified in this Booklet.

52) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to “Habilitative Services” as described in the “Benefits/Coverage (What is Covered)” section.

53) **Massage Therapy** For massage therapy and manipulative techniques or procedures.

53) Medical Equipment, Devices, and Supplies

a) Replacement or repair of purchased or rental equipment because of misuse, or loss/theft.

b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

c) Non-Medically Necessary enhancements to standard equipment and devices.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

d) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “Benefits/Coverage (What is Covered)” section.

54) **Medicare** If a medical service or supply is not covered under Medicare, then it is not a covered benefit under this plan.

55) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

56) **Non-approved Drugs** Drugs not approved by the FDA.

57) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

58) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines. Emergency medical care is not subject to this exclusion as long as such care meets the definition of Emergency medical care, see “Emergency Care” under the “Benefits/Coverage (What Is Covered)” section of this Booklet.

59) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, *nutritional formulas and dietary supplements that you can buy over-the-counter* and those you can get without a written Prescription or from a licensed pharmacist.

60) **Off label use** Off label use, unless we must cover it by law or if we approve it.

61) **Oral Surgery** Extraction of teeth, surgery for impacted teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

64) **Pain** Intractable Pain and/or Chronic Pain.

65) Personal Care, Convenience and Mobile/Wearable Devices

a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, dehumidifiers, sports helmets, raised toilet seats, shower chairs, special lighting or other environmental modifiers, wristlets, augmentative communication devices, surgical supports, and corsets or other articles of clothing,

b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

c) Home workout or therapy equipment, including treadmills and home gyms,

d) Pools, whirlpools, spas, or hydrotherapy equipment.

e) Hypo-allergenic pillows, mattresses, or waterbeds,

f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

66) **Prescription Drugs.** Prescription Drugs are excluded from Anthem medical coverage. See the pharmacy benefit book for prescription drug coverage provided by SilverScript (CVS Caremark)..

67) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Health Care Services" benefit.

68) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs, except as specifically stated in this Booklet, and scalp hair prosthetics.

69) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center**.** This Exclusion includes procedures, equipment, services, supplies or charges for the following:

a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

b. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

c. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

d. Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health or Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.

70) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” benefit.

71) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

72) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

73) **Sterilization** Services to reverse an elective sterilization.

74) **Studies** Research studies or screening exams, unless otherwise stated in this Booklet.

75) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) **Temporomandibular Joint Treatment**.

77) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

78) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

79) **Vision Services** Vision services not described as Covered Services in this Booklet.

80) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

81) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

    This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

82) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

Section 9. Member Payment Responsibility

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the “Definitions” section for a better understanding of each type of cost share.

Cost Sharing requirements are based on the Medicare allowed amount for services covered by Medicare up to the Maximum Allowed Amount of this Plan. For those services not covered by Medicare but that are covered under this Booklet your Cost Sharing requirements are based on Our Maximum Allowed Amount.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network Providers is based on this Booklet’s Maximum Allowed Amount for the Covered Service that you receive. Please see “Inter-Plan Arrangement’s” in the “Claims Procedure (How to File a Claim)” section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Except for Surprise Billing Claims*,when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Under certain circumstances, if We, on behalf of the Plan, pay the Provider amounts that are your responsibility, such as Deductibles or Coinsurance, We may collect such amounts directly from you. You agree that We, on behalf of the Plan, have the right to collect such amounts from you.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Section 10. Claims Procedure (How to File a Claim)

For services not covered by Medicare that are covered under this Booklet, when a PPO or Participating Provider bills Us for Covered Services, We will authorize payment from the Plan of the appropriate charges for the benefit directly to the Provider. You are responsible for providing the PPO or Participating Provider with all information necessary for the Provider to submit a claim. You pay the applicable Deductible and/or Coinsurance to the Provider when the Covered Service is received.

If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
  - Name of patient.
  - Patient's relationship with the Subscriber.
  - Identification number.
  - Date, type, and place of service.
  - Your signature and the Provider's signature.

  Out-of-Network claims must be submitted within 180 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180 day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

  Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate you will be responsible for any charge for services.

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. Where permitted by applicable law, we reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a “Qualified Medical Child Support Order” as having a right to enrollment under the Employer’s Plan), or that person’s custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or you) will discharge our obligation for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a “Qualified Medical Child Support Order” as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member, except as required by law. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA.

Section 11. General Policy Provisions

Assignment

Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in the “How to Access Your Services and Obtain Approval of Benefits (Applicable to Managed Care Plans)” and in “Claims Procedure (How to File a Claim)” sections.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the applicable laws, will hereby be automatically amended to conform with the minimum requirements of such laws.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of the Employer. Changes are further noted in “Modifications” below this section.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, we have adopted a Members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to anthem.com and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

This Booklet allows the Plan Administrator to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Only Agreement, or by mutual agreement between the Plan Administrator and Anthem without the permission or involvement of any Member. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Program(s) may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances,

In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Program(s) are not intended to affect your access to health care. The Program(s) payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. We may also offer, at our discretion, the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Claims Administrator offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of it, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. The Plan Administrator shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Anthem.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider, or otherwise make appropriate adjustment to claims. In most instances such

recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. Anthem reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Section 12. Termination/Nonrenewal/Continuation

Termination

Active Policy Termination
Your benefits end on the first occurrence of one of the following events:

- On the date the Plan described in this Booklet is terminated.
- Upon the Subscriber's death.
- When the required contribution has not been received by the employer.
- When you or your employer commits fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for benefits under the terms of this Booklet.
- When the Subscriber's employer gives Us written notice that the Subscriber is no longer eligible for benefits. Benefits will be terminated as determined by the employer. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive written notification to cancel coverage for any Member, benefits will end at the end of the month following the written notification or at the end of the month of the qualifying event.
- When We cease operations.

Dependent Coverage Termination
To remove a Dependent from the Plan, the Subscriber must complete a Benefits Enrollment/Change Form or online submission. The change will be effective at the end of the month We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

Benefits for a Dependent end on the last day of the month for the following qualifying events:

- When the Subscriber's employer notifies Us in writing to cancel benefits for a Dependent.
- When the Dependent child no longer qualifies as a Dependent by definition.
- On the date of a final divorce decree or legal separation for a Dependent Spouse or Partner.
- If you are a partner to a civil union or other relationship recognized as a spousal relationship in the state where the subscriber resides, on the date such union or relationship is revoked or terminated.
- When legal custody of a child placed for adoption is terminated.
- Death of the Dependent.

What We Will Pay for After Termination

We, on behalf of the Plan, will not authorize payment for any services provided after your benefits end even if we preauthorized the service, unless prohibited by law. Benefits cease on the date your participation ends as described above. You may be responsible for benefit payments authorized by Us on your behalf for services provided after your benefits have been terminated.

We do **not** cover services received after your date of termination even if:

- We preauthorized the service; and/or
- The services were made necessary by an accident, illness or other event that occurred while benefits were in effect.

Section 13. Appeals

We want your experience with us to be as positive as possible. There may be times, however, when you

have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the Member Services telephone number on the back of your ID card.

Appeals

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

The procedure Anthem will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, Anthem’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Anthem’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA within one year of the appeal decision if you submit an appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law. For claims involving urgent/concurrent care:
- Anthem’s notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Anthem's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

Anthem shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post- service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact Anthem at the phone number listed on your Health Benefit ID card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

For services that are **not** for Mental Health Conditions, Alcohol Dependency or Substance Dependency:

Anthem Blue Cross and Blue Shield
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

For services that are for Mental Health Conditions, Alcohol Dependency or Substance Dependency:

Anthem Blue Cross and Blue Shield
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

You must include Your Member Identification Number when submitting an appeal.

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or

- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

Anthem will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, Anthem will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When Anthem considers your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first- level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, Anthem will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, Anthem will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, Anthem will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

If Anthem fails to resolve the appeal within the required time, you may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between you and us.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from Anthem will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between the Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem at the phone number listed on your Health Benefit ID card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

You must exhaust the internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

If your health benefit Plan is sponsored by your employer and subject to the Employee Retirement Income

Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

The Plan reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Section 14. Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the Member Services telephone number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between HMO Colorado and the employer, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the administration of this Plan.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Applied Behavioral Analysis

The use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will not have to pay any more than the In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see "Claims Procedure (How to File a Claim)" for more details.

Benefit Maximum

The number of days or units of Covered Services, such as two office visits per your Benefit Period, for which a health coverage will provide benefits during a specified length of time.

Benefit Period

The length of time we will cover benefits for Covered Services (January 1 through December 31). If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits.

Chiropractic Care / Manipulative Therapy

A system of therapy that includes the therapeutic application of manual manipulation treatment, analysis and adjustments of the spine and other body structures, and muscle stimulation by any means, including therapeutic use of heat, cold, and exercise.

Chronic Pain

Pain that lasts more than six months that is not life threatening, and it may continue for a lifetime, and has not responded to current treatments.

Claims Administrator

An organization or entity that the employer contracts with to provide administrative and claims payment services under the Plan. The Administrator of this Plan is Anthem Blue Cross and Blue Shield. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Complications of Pregnancy

Complications of Pregnancy means:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. This does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;
- Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Congenital Defect

A defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if Precertification or prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or Mental Health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility" section and who has enrolled in the Plan.

Doctor

Please see the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "Benefits/Coverage (What is Covered)" section.

Emergency Care

Please see the "Benefits/Coverage (What is Covered)" section.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with Anthem to administer this Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which we determine in our sole discretion to be Experimental or Investigational.

   We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental or Investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

   The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

   - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted;
   - Has been determined by the FDA to be contraindicated for the specific use;
   - Is provided as part of a clinical research protocol or clinical trial (except as noted in the Clinical Trials section under Covered Services in this Booklet as required by state law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
   - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

b) Any service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by us. In determining whether a service is Experimental or Investigational, we will consider the information described in subsection (c) and assess all of the following:

   - Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;
   - Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives; or
   - Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

c) The information we consider or evaluate to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal;
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, or Skilled Nursing Facility, Mental Health as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Fee(s)

The amount you must pay to be covered by this Plan.

Habilitative Services

Habilitative Services help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care

2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card (ID Card)

The card we give you that shows your Member identification, Group numbers, and the plan you have.

Infertility

Infertility, which may occur in either male or female, means a disease or condition characterized by the failure to impregnate or conceive, a person's inability to reproduce either as an individual or with the person's partner, or by the findings of a based on a person's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. As used in this definition, a "failure to impregnate or conceive" means the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination for a woman under the age of thirty-five or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a woman thirty-five or older. Conception resulting in a miscarriage does not restart the twelve- or six-month clock to qualify as having infertility.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Services

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or Substance Use Disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Intractable Pain

A pain state in which the cause of the pain cannot be removed and which in the course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. It includes evaluation by the attending Doctor and one or more Doctors specializing in the treatment of the part of the body thought of as the source of pain.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility" section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Member Payment Responsibility” section.

Medical Necessity (Medically Necessary)

The diagnosis, evaluation and treatment of a condition, illness, disease or injury that we solely decide to be:

- Medically appropriate for and consistent with your symptoms and proper diagnosis or treatment of your condition, illness, disease or injury;
- Obtained from a Doctor or Provider;
- Provided in line with medical or professional standards;
- Known to be effective, as proven by scientific evidence, in improving health;
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted. It will need to be consistent with recognized professional standards of care. In the case of a Hospital stay, also means that safe and adequate care could not be obtained as an outpatient;
- Cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting;
- Not Experimental or Investigational;
- Not primarily for you, your families, or your Provider’s convenience; and
- Not otherwise an exclusion under this Booklet.

The fact that a Doctor or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Use Disorder (Behavioral, Mental Health and Substance Use Disorder)

A condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of (a) the international statistical classification of diseases and related health problems; (b) the Diagnostic and Statistical Manual of Mental Disorders (DSM); or (c) the diagnostic classification of Mental Health and developmental disorders of infancy and early childhood. The phrase also includes Autism Spectrum Disorders, as defined in this Booklet.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the “Eligibility” section for more details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Fee, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The Plan Administrator's benefit plan, which is described in this Booklet.

Plan Administrator

The entity which is responsible for the administration of the plan: CU Health Plan Administration.

Precertification

Please see the section "How to Access Your Services and Obtain Approval of Benefits" for details.

Primary Care Physician / Provider ("PCP")

A Provider who gives or directs health care services for you. The Provider may work in family practice, general practice, internal medicine, pediatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, , must satisfy our accreditation requirements and be approved by us.. Details on our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the amount determined by a specified state law; the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Residential Treatment Center / Facility:

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation, and be approved by us.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Subscriber

An employee or member of the Employer who is eligible for and has enrolled in the Plan.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

A set of formal techniques to monitor or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and/or retrospective review. Utilization Review also includes reviewing whether or not a procedure or treatment is considered Experimental or Investigational, and reviewing your medical circumstances when such a review is needed to determine if an exclusion applies.

End of Anthem Medical Booklet

Please see the SilverScript (CVS Caremark) booklet for Prescription Coverage Information

Get help in your language

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone Member Services telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Bassa
M̃ bédé dyí-bèdɛ̀ìn-dɛ̀ɔ̀ bé m̀ ké bɔ̃̀ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ bídí-wùdùŭn bó pídyi. Đá mébà jè gbo-gmɔ̀ Kpòè nɔ̀bà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ bé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။
(TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。
(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કૉલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មានេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ ່ານມ ີສ ິດໄດ ້ຮ ັບຂ ໍ ້ມ ູນ ີ ແລະ
ຄວາມຊ ່ ວຍເຫ ຼ ືອ ເປ ັ ນພ າສ າຂ ອງທ ່ ານໂດຍ ບ ໍ ່ ເສ ຍ ຄ ່ າ.
ໂທຫ າ ເບ ິ ໂທຂ ອງ ໝ ່ ายบ ໍ ລ ິ ການສ ະມ າຊ ິ ກ ທ ີ ່ ໃ ຫ ້ ໄ ວ ້ ໃ ນ ບ ັ ດ ປ ະ ຈ ໍ າ ຕ ົ ວ ຂ ອ ງ ທ ່ ານ ເ
ພ ื ่ อ ຂ ໍ ຄ ວ າ ມ ຊ ่ ວ ຍ ເ ຫ ຼ ื อ ຍ. (TTY/TDD: 711)

Navajo
Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800- 368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.

Section 15. Thank You from Anthem

The medical benefits described in this Booklet are paid by CU Health Plan. Anthem Blue Cross and Blue Shield ("Anthem") provides administrative claims payment services as described before this page.

Thank you for selecting Anthem Blue Cross and Blue Shield for your medical health care coverage.

SilverScript®

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

CU Health Plan

January 1, 2025 - December 31, 2025

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of SilverScript Employer PDP sponsored by CU Health Plan (SilverScript)

This document gives you the details about your Medicare prescription drug coverage from January 1, 2025 - December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at 1-833-252-6640. (TTY users should call 711). Hours are 24 hours a day, 7 days a week. This call is free.

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

This document is available for free in Spanish.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2026.

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

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

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

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OMB Approval 0938-1051 (Expires: August 31, 2026)

2025 Evidence of Coverage

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CHAPTER 1

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in SilverScript, which is a Medicare prescription drug plan

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

SilverScript 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* document about?

This *Evidence of Coverage* document tells you how to get your prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words coverage and covered drugs refer to the prescription drug coverage available to you as a member of SilverScript.

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for the months in which you are enrolled in SilverScript between January 1, 2025, and December 31, 2025.

Each year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of SilverScript after December 31, 2025. We can also choose to stop offering the plan in your service area, after December 31, 2025.

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

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

Section 2.1 Your eligibility requirements

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

- CU Health Plan has determined that you are eligible for this plan
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B)
- – *and* – you are a United States citizen or are lawfully present in the United States
- – *and* – you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is the plan service area for SilverScript

SilverScript is available only to individuals who live in our plan service area. To remain a member of our plan, you must live in the United States or its territories. Please note: If you use a post office box, you will need to provide proof that you live in our service area.

If you plan to move out of the service area, please contact Customer Care. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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

Please carry your card with you at all times, and remember to show your card when you get covered prescription drugs. If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card. You may need to use your existing medical card or your red, white, and blue Medicare card to get covered medical care and services.

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

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

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

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Care. **Please review the 2025 *Pharmacy Directory* to see which pharmacies are in our network. It can be found online at SilverScriptEmployerPDP.MemberDoc.com.**

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in SilverScript. The prescription drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the SilverScript "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." To get the most complete and current information about which drugs are covered, you can view your formulary online at **SilverScriptEmployerPDP.MemberDoc.com** or call Customer Care. We will also continue to update our online drug pricing tool as scheduled and provide other required information to reflect drug changes.

SECTION 4 Your monthly costs for SilverScript

Your costs may include the following:

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

Please contact CU Health Plan for more information about the premium for this plan.

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

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

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

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

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called “2025 Medicare Costs.” If you need a copy, you can download it from the Medicare website (www.medicare.gov/medicare-and-you). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan Premium

Please contact CU Health Plan for more information about the premium for this plan.

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

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

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

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

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

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

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year. For 2025, the average premium amount is $36.78.
- 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 $36.78, which equals $5.15. This rounds to $5.20. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

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

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 7 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

Section 5.1 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 October, 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. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover, if applicable. A member who loses his/her eligibility during the year will need to start paying his/her full monthly premium, if applicable. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, address, or phone number
- Changes in any other medical or prescription drug insurance coverage you have, such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid
- If you have any liability claims, such as claims from an automobile accident

- If you have been admitted to a nursing home
- If your designated responsible party, such as a caregiver, changes

If any of this information changes, please let us know by contacting Customer Care.

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

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

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

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

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

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

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

CHAPTER 2

Important phone numbers and resources

SECTION 1 SilverScript contacts (how to contact us, including how to reach Customer Care)

How to contact Customer Care

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

Customer Care – Contact Information	
CALL	1-833-252-6640 Calls to this number are free, 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-866-552-6205
WRITE	SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330
WEBSITE	Caremark.com

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

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

Coverage Decisions and Appeals for Part D Prescription Drugs – Contact Information	
CALL	1-833-252-6640 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-855-633-7673
WRITE	SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department P.O. Box 52000, MC 109 Phoenix, AZ 85072-2000

How to contact us when you are making a complaint

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

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

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

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

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

Payment Requests – Contact Information	
CALL	1-833-252-6640 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
WRITE	SilverScript Insurance Company Prescription Drug Plans Medicare Part D Paper Claim P.O. Box 52066 Phoenix, AZ 85072-2066

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

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

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

Medicare – Contact Information	
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Medicare – Contact Information

You can also use the website to tell Medicare about any complaints you have about SilverScript.

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

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

SECTION 4 Quality Improvement Organization

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

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

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

SECTION 5 Social Security

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

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

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

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

SECTION 6 Medicaid

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

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

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

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

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

The Medicare.gov website (https://www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

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

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

- 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 or
- Your State Medicaid Office (See the Appendix at the end of this document for contact information.)

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

Documentation from the state or Social Security showing your low income subsidy level is the preferred evidence of your proper cost sharing level. Please fax your documentation to us at 1-866-552-6205 . Please include a phone number where we can contact you. If you cannot provide the documentation and need assistance or would like additional information, contact Customer Care, 24 hours a day, 7 days a week, at 1-833-252-6640. TTY users should call 711.

- SilverScript Insurance Company will accept any of the following documents as evidence:
    - A copy of your Medicaid card, which includes your name and eligibility date during the period for which you believe you qualified for "Extra Help;"
    - Details of any call you made to verify your Medicaid status, including the date a verification call was made to the state Medicaid agency and the name, title, and telephone number of the state staff person who verified your Medicaid status during the discrepant period;
    - A copy of a state document that confirms your active Medicaid status during the discrepant period;
    - A printout from the state electronic enrollment file showing your Medicaid status during the discrepant period;
    - A screen-print from the state's Medicaid systems showing your Medicaid status during the discrepant period;
    - Other documentation provided by the state showing your Medicaid status during the discrepant period;
    - A letter from Social Security showing that the individual receives Supplemental Security Income (SSI); or
    - An "Important Information" letter from Social Security confirming that the beneficiary is "automatically eligible for 'Extra Help.'"
- For beneficiaries who are institutionalized and qualify for zero cost sharing, the following documents will be accepted as evidence of your proper cost sharing level:
    - A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
    - A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
    - A screen-print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

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

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

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums, and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), "Medicare's Extra Help" pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)? 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 on the ADAP formulary qualify for prescription cost sharing assistance through your state's ADAP program.

Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your State-specific ADAP using the contact information in the Appendix at the end of this booklet.

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. Please see the Appendix at the end of this document to find the contact information for the SPAP in your state.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

The Medicare Prescription Payment Plan - Contact Information	
CALL	1-833-252-6640 Calls to this number are free, 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
WRITE	SilverScript Insurance Company P.O. Box 7 Pittsburgh, PA 15230
WEBSITE	Caremark.com

SECTION 8 How to contact the Railroad Retirement Board

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

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

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

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

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

CHAPTER 3

Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

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

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

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

The two examples of prescription drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2025* handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.1 Basic rules for the plan's Part D prescription drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter.) Or you can fill your prescription 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 in this chapter.) *Your prescription drugs on the plan's "Drug List" are covered by the Medicare Part D portion of your benefit.*
- **Please note:** The "Drug List" does not include any drugs covered by the additional coverage provided by CU Health Plan.
- Your drug must be used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 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 (Caremark.com), and/or call Customer Care.

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

Through the additional coverage provided by CU Health Plan, you may be able to save on your maintenance prescription drugs by changing your 30-day supply to a 90-day supply at any CVS Pharmacy®, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location. These pharmacies are called "preferred network retail pharmacies."

If you're currently taking any long-term prescription drugs, you can continue to fill your 30-day supplies. However, you may save by changing your 30-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 30-day supplies of the same prescription drug.

You can choose from two 90-day supply options for the same low price.

Option 1: Refill at any CVS Pharmacy, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location, and pick up your prescription drugs at your convenience.

Option 2: Refill with CVS Caremark Mail Service Pharmacy and have a 90-day supply of your long-term prescription drugs shipped to your home.

For questions about maintenance drugs with additional coverage provided by CU Health Plan, including the cost to fill these drugs, please contact Customer Care.

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. If the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Customer Care or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply prescription drugs for home infusion therapy.

- Pharmacies that supply prescription drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense prescription drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your *Pharmacy Directory* (Caremark.com) or call Customer Care.

Section 2.3 Using the plan's mail-order service

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

Our plan's mail-order service allows you to order **up to a 90-day supply.** Filling one 90-day supply with the CVS Caremark Mail Service Pharmacy can sometimes cost you less than three 30-day supplies of the same prescription drug.

To get order forms and information about filling your prescriptions by mail, please visit Caremark.com or contact Customer Care.

Usually a mail-order pharmacy order will be delivered to you in no more than 10 days. If the mail-order pharmacy expects the order to be delayed, they will contact you and help you decide whether to wait for the medication, cancel the mail-order, or fill the prescription at a local pharmacy. If you need to request a rush order because of a mail-order delay, you may contact Customer Care to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second day or next day delivery of your medications, you may request this from the Customer Care representative for an additional charge.

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

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

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please log on to your Caremark.com account or contact Customer Care.

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

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show you should be close to running out of your drug.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 15 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please log on to your Caremark.com account or contact Customer Care.

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

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

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance prescription drugs at a lower cost sharing amount. Other retail pharmacies may not agree to the lower cost sharing amounts. In this case, you will be responsible for the difference in price. Your *Pharmacy Directory* (Caremark.com) tells you which pharmacies in our network can give you a long-term supply of maintenance prescription drugs. You can also call Customer Care for more information.
2. Our plan's mail-order service allows you to order up to a 90-day supply. See Section 2.3 of this chapter for more information about using our mail-order services.

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

Your prescription may be covered in certain situations

Generally, we cover a 30-day supply of drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. **Please check first with Customer Care** to see if there is a network pharmacy nearby. 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.

Here are the circumstances when we would cover a 30-day supply of prescriptions filled at an out-of-network pharmacy:

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost for a 30-day supply. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

If you must use an out-of-network pharmacy in these situations, we will reimburse you your total cost minus your cost share amount for a 30-day supply of the prescription drug. You must submit a paper claim in order to be reimbursed.

Please check first with Customer Care to see if there is a network pharmacy nearby.

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

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

The drugs on the "Drug List" are only those covered under Medicare Part D.

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

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

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

Please contact Customer Care for any questions regarding your additional benefit.

The "Drug List" includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the "Drug List", when we refer to *drugs*, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 10 for definitions of the types of drugs that may be on the Drug List.

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 of this chapter.)
- In other cases, we have decided not to include a particular drug on the "Drug List". In some cases, you may be able to obtain a drug that is not on the "Drug List". (For more information, please see Chapter 7.)

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

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

Every prescription 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:

- **Cost Sharing Tier 1: Generic**
- **Cost Sharing Tier 2: Preferred Brand**
- **Cost Sharing Tier 3: Non-Preferred Brand**
- **Cost Sharing Tier 4: Specialty (High Cost)**

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

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

Please note: CU Health Plan provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit. For more information about your share of the cost or which prescription drugs may or may not be covered, please call Customer Care.

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

You have four ways to find out:

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

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

Please note: CU Health Plan provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit. For more information about your share of the cost or which prescription drugs may or may not be covered, please call Customer Care. You may view this list of drugs, and any restrictions, on our website, Caremark.com.

Section 4.2 What kinds of restrictions?

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

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

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

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

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

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost sharing tier that makes your share of the cost more expensive than you think it should be.

- There are things you can do if your drug is not covered in the way that you'd like it to be covered. **If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.**
- **If your drug is in a cost sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.**

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

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

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

You may be able to get a temporary supply

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

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

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

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

For questions about a temporary supply, call Customer Care.

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

1) You can change to another drug

CU Health Plan provides additional coverage for some prescription drugs not covered by SilverScript. If your drug is not covered, you may talk with your provider. Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells 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.

Prescription drugs in some of our cost sharing tiers are not eligible for this type of exception. We do not lower the cost sharing amount for prescription drugs in Tier 4: Specialty (High Cost).

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost sharing tier that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered prescription drug that might work for you.

You can ask for an exception

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

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

Prescription drugs in some of our cost sharing tiers are not eligible for this type of exception. We do not lower the cost sharing amount for prescription drugs in Tier 4: Specialty (High Cost).

Drugs in some of our cost sharing tiers are not eligible for this type of exception. We do not lower the cost sharing amount for drugs in the "Preferred" tiers, for any drug in the "Specialty" tier, or any drugs in Tier 1. Coverage of any non-formulary drug is not eligible for a tiering exception.

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

CU Health Plan is providing additional coverage to your Medicare Part D prescription drug plan. The additional coverage may cover this medication. For more information on your coverage, please contact Customer Care.

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

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

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

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

See Chapter 10 for definitions of the drug types discussed in this chapter.

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

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We will make these changes only if we are adding a new generic version of a brand name drug on the Drug List or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market.**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List". If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs on the "Drug List"**
    - We may make other changes once the year has started that affect drugs you are taking. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - We will tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you are taking.

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

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

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

In general, changes that will not affect you during the current plan year are:

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

If any of these changes happen for a prescription drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other changes noted in the section above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We will not tell you about these types of changes directly during the current plan year. You will need to check the "Drug List" for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

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

Section 7.1 Types of prescription drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself, (except for certain excluded drugs covered through the additional coverage provided by CU Health Plan.) If you appeal and the requested prescription drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

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

- Our plan's Part D prescription drug coverage cannot cover a prescription drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a prescription drug purchased outside the United States or its territories.

- Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

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

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

The additional coverage provided by CU Health Plan covers certain prescription drugs not covered under Medicare Part D; this is identified in Chapter 3, Section 3.1 of this document. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 6 of this document.)

If you are receiving **"Extra Help"** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have prescription 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 prescription drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the Appendix.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your SilverScript plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. This includes any additional coverage provided by CU Health Plan. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

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

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

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

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

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

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

In addition to coverage in SilverScript sponsored by CU Health Plan, if you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** They can help you determine how your current prescription drug coverage will work with our plan.

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

Special note about creditable coverage:

If you currently have prescription drug coverage, other than your coverage in SilverScript sponsored by CU Health Plan, that group's benefits administrator should send you a notice each year that tells if your prescription drug coverage for the next calendar year is creditable.

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

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

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

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

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

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

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

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

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Care.

CHAPTER 4

What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

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

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" on Caremark.com to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Customer Care.

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

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

- **Deductible** is the amount you must pay for drugs before our plan begins to pay its share. You have no deductible for SilverScript and begin coverage in the Initial Coverage Stage when you fill your first prescription of the year.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

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

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs, and you followed the rules for drug coverage that are explained in Chapter 3):

- The amount you pay for drugs when you are in the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this plan year under another Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself,** they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,000 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 Medicare out-of-pocket costs

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

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under the additional coverage provided by CU Health Plan but not normally covered in a Medicare prescription drug plan.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments for your drugs that are made by the Veterans Health Administration (VA).
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation.)
- Payments made by drug manufacturers under the Manufacturer Discount Program.

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

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

- We will help you. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your Medicare out-of-pocket costs. When this amount reaches $2,000, 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 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 SilverScript members?

There are three drug payment stages for your prescription drug coverage under SilverScript. How much you pay depends on what stage you are in at the time you get a prescription filled or refilled.

Maximum Out-of-Pocket

After you reach your individual maximum out-of-pocket costs of $1,200, CU Health Plan will pay the rest of your annual drug costs.

Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

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

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

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

- We keep track of how much you have paid. This is called your **Out-of-Pocket Cost**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at a pharmacy and have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program (SPAP), an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call Customer Care. You have the option to receive your Part D EOB electronically by registering at Caremark.com. The digital format of the EOB provides the same information as the paper copy you receive in the mail today. Once registered at Caremark.com, you will be able to view, save, or print your EOBs and other plan documents. You will receive email notification when you have a new EOB to view. Be sure to keep these reports.

SECTION 4 There is no deductible for SilverScript

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

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

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

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

The plan has 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:

- **Cost Sharing Tier 1: Generic**
- **Cost Sharing Tier 2: Preferred Brand**
- **Cost Sharing Tier 3: Non-Preferred Brand**
- **Cost Sharing Tier 4: Specialty (High Cost)**

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

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Your pharmacy choices

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

- A network retail pharmacy – see Section 5.2 of this chapter.
- A preferred network pharmacy that offers preferred cost sharing (for maintenance prescription drugs at 90 days) – see Section 5.4 of this chapter. Costs may be less at pharmacies that offer preferred cost sharing.
- A standard network pharmacy that offers standard cost sharing – see Section 5.4 of this chapter.
- The plan's mail-order pharmacy.
- A pharmacy that is not in the plan's network. We cover a 30-day supply of prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.

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

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

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

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

Please note: If your covered drug costs less than the 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 coinsurance up to the per-prescription minimum or maximum amount, *whichever is lower.*

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug before your individual maximum out-of-pocket is met:

	Network Retail Pharmacy (Up to a 30-day supply available at **any** network pharmacy)	**Mail-Order Pharmacy** (Up to a 30-day supply)	**Long-Term Care (LTC) Pharmacy** (Up to a 31-day supply)
Tier 1: Generic	$10.00	$10.00	$10.00
Tier 2: Preferred Brand	$50.00	$50.00	$50.00
Tier 3: Non-Preferred Brand	$75.00	$75.00	$75.00
Tier 4: Specialty (High Cost)	$100.00	$100.00	$100.00

Please note, if you go to an out-of-network pharmacy, and are in one of the limited situations described in Chapter 3, Section 2.5, you will be reimbursed the cost of the 30-day supply of the drug less your cost share, which will be the same as a 30-day supply at a standard network retail pharmacy listed in the above table.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on cost sharing for Part D vaccines.

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

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

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower, since the total cost for the drug will be lower.

- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost sharing rate) and multiply it by the number of days of the drug you receive.

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

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

The following table shows what you pay when you get a long-term 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 before your individual maximum out-of-pocket is met:

	Preferred Network Retail Pharmacy (Up to a 90-day supply)	**Standard Network Retail Pharmacy** (Up to a 90-day supply)	**Mail-Order Pharmacy** (Up to a 90-day supply)
Tier 1: Generic	$20.00	$30.00	$20.00
Tier 2: Preferred Brand	$100.00	$150.00	$100.00
Tier 3: Non-Preferred Brand	$150.00	$225.00	$150.00
Tier 4: Specialty (High Cost)	N/A	N/A	N/A

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Through the additional coverage provided by CU Health Plan, you may be able to save on your maintenance prescription drugs by changing your 30-day supply to a 90-day supply at any CVS Pharmacy, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location. These pharmacies are called "preferred network retail pharmacies."

If you are currently taking any long-term prescription drugs, you can continue to fill your 30-day supplies. However, you may save by changing your 30-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 30-day supplies of the same prescription drug.

You can choose from two 90-day supply options for the same low price.

Option 1: Refill at any CVS Pharmacy, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location, and pick up your prescription drugs at your convenience.

Option 2: Refill with CVS Caremark Mail Service Pharmacy and have a 90-day supply of your long-term prescription drugs shipped to your home.

For questions about maintenance drugs with additional coverage provided by CU Health Plan, including the cost to fill these drugs, please contact Customer Care.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.

CU Health Plan provides additional coverage on some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count toward your Medicare Part D total out-of-pocket costs. To find out which drugs our plan covers, please call Customer Care.

The *Part D EOB* that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf for your drugs during the year. Not all members will reach the $2,000 out-of-pocket limit in a year.

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

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under the additional coverage provided by CU Health Plan.

SECTION 7 CU Health Plan Annual Maximum Out-of-Pocket (MOOP)

Section 7.1 CU Health Plan Annual Maximum Out-of-Pocket (MOOP)

Maximum Out-of-Pocket (MOOP) – The most a person will pay in a year for deductibles and copayments/coinsurance for covered benefits. This amount can vary by plan.

After you reach your individual maximum out-of-pocket costs of $1,200, CU Health Plan will pay the rest of your annual drug costs.

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

Important Message About What You Pay for Vaccines — Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List". Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's "Drug List" or contact Customer Care for coverage and cost sharing details about specific vaccines.

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

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

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

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

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

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

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

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

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

- Our plan will pay the remainder of the costs.

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

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

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

CHAPTER 5

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

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

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

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

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

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

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

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

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

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

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

   - For example, the prescription drug may not be on the plan's "Drug List", or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the prescription drug immediately, you may need to pay the full cost for it.

Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

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

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

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. Ensure you provide this information no later than three (3) years from the date of service. Claims submitted after that date may not be processed.

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.
- Call Customer Care and ask for the form.

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

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

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

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

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

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). We will mail payment within 30 days after your request was received.
- If we decide that the prescription drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6

Your rights and responsibilities

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

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

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with SilverScript Insurance Company, Grievance Department, P.O. Box 14834, Lexington, KY 40512. Fax 1-724-741-4956. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697).

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

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

As a member of SilverScript, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network pharmacies.** You have the right to get information from us about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your SHIP. Contact information is in the Appendix at the end of this document.

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

If you have any problems, concerns, or complaints and need to request coverage or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we are required to treat you fairly.**

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

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

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

- **Get familiar with your covered prescription drugs and the rules you must follow to get these covered prescription drugs.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered prescription drugs.
    - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the prescription drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You, or CU Health Plan, must pay your plan premiums.

      For most of your prescription drugs covered by the plan, you must pay your share of the cost when you get the prescription drug.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area,** you cannot remain a member of our plan.
- **If you move,** it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7

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

SECTION 1 Introduction

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

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

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints;** also called grievances.

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

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

Section 1.2 What about the legal terms?

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

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than 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. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

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

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

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

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or *fast appeal* of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. Part D appeals are discussed further in Section 5 of this chapter.) If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal. (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes.)

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

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

- You **can call us at Customer Care.**
- You **can get free help from** your State Health Insurance Assistance Program.

- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
      The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline (noted in following sections) for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

Section 5.1 This section tells 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 include coverage for many prescription drugs. To be covered, the prescription drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, please see Chapters 3 and 4.

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

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 5.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first). **Ask for an exception. Section 5.2**
- Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier, if applicable to your plan. **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

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

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

Section 5.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the "Drug List" is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

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

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

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

2. **Removing a restriction for a covered drug.** Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our "Drug List". If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost sharing tier**, if applicable to your plan. Every drug on our "Drug List" is in one of 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.
   - 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 a lower cost sharing amount. This would be the lowest tier cost that contains biological product alternatives for treating your condition.
   - If the drug you're taking is a brand name drug, you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
   - 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 the Specialty (High Cost) tier.
   - If we approve your tiering exception request and there is more than one lower cost sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

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

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

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

- You must be asking for a *drug you have not yet received*. (You cannot ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.

- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

We must generally give you our answer within **24 hours** after we receive your request.

- For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must generally give you our answer **within 72 hours** after we receive your request.

  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

Section 5.5 Step-by-step: How to make a Level 1 appeal

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

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

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

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

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at the phone number shown in Chapter 2, Section 1.**
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website (Caremark.com). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

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

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

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

<u>Step 4:</u> If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

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

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

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

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

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

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

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

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **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.

For standard appeals:

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

What if the review organization says no to your appeal?

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

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

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

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

SECTION 6 Taking your appeal to Level 3 and beyond

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

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any

further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

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

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

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

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

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

MAKING COMPLAINTS

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

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

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

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

Section 7.2 How to make a complaint

Legal Terms

- A **complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 7.3 Step-by-step: Making a complaint

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

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

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

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

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

- You may request an Expedited Grievance by calling Customer Care. We will contact you within 24 hours by phone to notify you of our response. This will also be followed up by a written response.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

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

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

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

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

Or

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

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about SilverScript directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

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

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

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

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

You can end your membership in our plan during the **Annual Enrollment Period for CU Health Plan**. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period for CU Health Plan** is from October 7, 2024 to October 18, 2024.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare prescription drug plan.
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan.
        - If you choose this option, Medicare may enroll you in a prescription drug plan, unless you have opted out of automatic enrollment.
    - – *OR* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
        - If you enroll in most individual Medicare health plans, you will be disenrolled from SilverScript when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D prescription drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep SilverScript for your prescription drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

- Your membership will end in our plan when your new plan's coverage begins on January 1, 2026.

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

  - **Please note:** This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than SilverScript, you may lose your medical and prescription drug coverage provided by CU Health Plan.

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

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

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples. For the full list you can contact the plan, call Medicare, or visit the Medicare website www.medicare.gov:
  - If you have moved out of your plan's service area.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Care.
  - **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.
- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period,** please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
  - Another Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row,

you may have to pay a Part D late enrollment penalty if you join a Medicare prescription drug plan later.

- **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a prescription drug plan, unless you have opted out of automatic enrollment.

- – *OR* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
  - If you enroll in most individual Medicare health plans, you will be disenrolled from SilverScript when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D prescription drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep SilverScript for your prescription drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

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

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

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

- **Contact Customer Care.**
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY: 1-877-486-2048.)

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

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from SilverScript when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from SilverScript 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 SilverScript for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Customer Care if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

Until your membership ends and your new Medicare coverage begins, you must continue to get your prescription drugs through our plan. **You should continue to use our network pharmacies to get your prescriptions filled.**

If you use an out-of-network pharmacy, we will reimburse you your total cost minus your share of the cost for a 30-day supply of the prescription drug. You must submit a paper claim in order to be reimbursed. Please see Chapter 3, Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.

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

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

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

Where can you get more information?

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

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

SilverScript is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 9

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call us at Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Other important legal notices

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

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Annual Enrollment Period – The time period of October 7, 2024 until October 18, 2024 when members can change their health or prescription drug plans or switch to Original Medicare.

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products. (See also "Original Biological Product" and "Biosimilar").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (See "**Interchangeable Biosimilar**.")

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 in covered prescription drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under the additional coverage provided by CU Health Plan

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422 (a)(1)(iv).

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

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when prescription drugs are received. This is in addition to the plan's monthly premium. Cost sharing includes any combination of the following three types of payments: (1) any "deductible" amount a plan may impose before prescription drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific prescription drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a prescription drug, that a plan requires when a specific prescription drug is received.

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

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

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

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

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

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

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

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

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a prescription drug that is not on our formulary (a formulary exception), or get a non-preferred prescription drug at a lower cost sharing level (a tiering exception). You may also request an exception if SilverScript requires you to try another prescription drug before receiving the prescription drug you are requesting, if your plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the prescription drug you are requesting (a formulary exception).

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

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

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

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

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered prescription drugs to members of our plan.

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

- **CU Health Plan Annual Maximum Out-of-Pocket (MOOP)** – The most you will pay in a year for your share of the cost for covered prescription drugs.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

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

Part C – See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare prescription drug benefit program.

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

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

Preferred Cost Sharing – Preferred cost sharing means lower costs for certain covered Part D prescription drugs (i.e., for maintenance prescription drugs at 90 days) at preferred network pharmacies.

Preferred Network Pharmacy – A network retail pharmacy that accepts the plan's preferred cost sharing for maintenance prescription drugs at 90 days.

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

Prior Authorization – Approval in advance to get certain prescription drugs. Covered prescription drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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

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

Real–Time Benefit Tool – An online drug pricing tool within your secure member portal at Caremark.com in which enrollees can look up specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Service Area – A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

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

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

Standard Network Pharmacy – A network retail pharmacy that accepts the plan's standard cost sharing.

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

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

Important Contact Information for State Agencies

	Quality Improvement Organizations (QIO)
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-319-8452, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 2: New Jersey, New York, Puerto Rico, Virgin Islands	**Livanta**, **Address:** Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, **Phone:** 1-866-815-5440, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	**Livanta**, **Address:** Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, **Phone:** 1-888-396-4646, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0751, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	**Livanta**, **Address:** Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, **Phone:** 1-888-524-9900, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-315-0636, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 7: Iowa, Kansas, Missouri, Nebraska	**Livanta**, **Address:** Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, **Phone:** 1-888-755-5580, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0891, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 9: American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	**Livanta**, **Address:** Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, **Phone:** 1-877-588-1123, American Samoa (684) 699-3330, Guam (671) 685-2689, Northern Mariana Islands (670) 989-2686, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en

	Quality Improvement Organizations (QIO)
Region 10: Alaska, Idaho, Oregon, Washington	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-305-6759, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com

	State Medicaid Office
AK	**Alaska Medicaid**, **Address:** Alaska Department of Health, Division of Public Assistance, PO Box 110640, 350 Main Street, Room 304, Juneau, AK 99811-0640, **Phone:** 1-800-780-9972 (coverage or billing), 1-800-478-7778 (eligibility), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx
AL	**Alabama Medicaid Agency**, **Address:** Central Office, 501 Dexter Avenue, Montgomery, Alabama 36104, **Phone:** 1-800-362-1504, 334-242-5000, **TTY:** 1-800-253-0799 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** medicaid.alabama.gov/
AR	**Arkansas Medicaid**, **Address:** Arkansas Department of Human Services, PO Box 1437, Slot S401, Little Rock, AR 72203-1437, **Phone:** 1-800-482-8988, 1-800-482-5431, **TTY:** 501-682-8933 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** humanservices.arkansas.gov/divisions-shared-services/medical-services/
AS	**American Samoa Medicaid State Agency**, **Address:** PO Box 998383, Pago Pago, AS 96799, **Phone:** 684-699-4777, 684-699-4778, **TTY:** 711, **Hours:** Monday-Friday 8:00 AM-5:00 PM, **Website:** medicaid.as.gov
AZ	**Arizona Health Care Cost Containment System (AHCCCS)**, **Address:** Office of Individual and Family Affairs (OIFA), 801 E. Jefferson Street, Phoenix, AZ 85034, **Phone:** 1-800-654-8713, 602-417-4000, **TTY:** 1-800-842-6520 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 9:00 PM, Saturday 8:00 AM to 6:00 PM, **Website:** azahcccs.gov/
CA	**Medi-Cal (California's Medicaid program)**, **Address:** California Department of Health Care Services, 1501 Capitol Avenue, Sacramento, CA 95814, **Phone:** 1-800-541-5555, 916-552-9200, **TTY:** 1-800-430-7077 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhcs.ca.gov/services/medi-cal/Pages/default.aspx
CO	**Health First Colorado**, **Address:** Colorado Department of Health Care, Policy & Financing, 303 E. 17th Avenue, Denver, CO 80203, **Phone:** 1-800-221-3943, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** healthfirstcolorado.com/
CT	**HUSKY Health (Connecticut's Medicaid program)**, **Address:** HUSKY Health Program, c/o Department of Social Services, 55 Farmington Ave., Hartford, CT 06105-3724, **Phone:** General Information: 1-877-284-8759, Member Services 1-800-859-9889, **TTY:** 1-866-492-5276 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** General Information: Monday–Friday 7:30 AM to 4:00 PM, Member Services: Monday–Friday 8:00 AM to 6:00 PM, **Website:** portal.ct.gov/HUSKY/Welcome

	State Medicaid Office
DC	**DC Medicaid**, **Address:** The Department of Health Care Finance – DHCF, 441 4th Street NW, 900S, Washington, DC 20001, **Phone:** 202-442-5988, **TTY:**711, **Hours:** Monday–Friday 8:15 AM to 4:45 PM, **Website:** dhcf.dc.gov/service/medicaid
DE	**Delaware Medicaid**, **Address:** Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA), 1901 N. DuPont Highway, New Castle, DE 19720, **Phone:** 1-866-843-7212, 302-571-4900, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhss.delaware.gov/dhss/dmma/medicaid.html
FL	**Florida Division of Medicaid**, **Address:** Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308, **Phone:** 1-877-711-3662, 850-412-4000, **TTY:** 1-866-467-4970 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Thursday, 8:00 AM to 8:00 PM, Friday 8:00 AM to 7:00 PM, **Website:** ahca.myflorida.com/medicaid
GA	**Georgia Medicaid**, **Address:** The Department of Community Health (DCH), 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334, **Phone:** Toll Free: 1-877-423-4746, Customer Service: (404) 657-5468, Eligibility: 404-651-9982, Member Services: 866-211-0950, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.georgia.gov/
GU	**Guam Medicaid**, **Address:** Department of Public Health & Social Services, 761 South Marine Corps Drive, Tamuning, GU 96913, **Phone:** 671-300-7330, **TTY:**711, **Hours:** 8:00 AM to 4:00 PM, **Website:** dphss.guam.gov
HI	**Hawaii Med-QUEST (Quality, Universal Access, Efficiency, Sustainability, Transformation)**, **Address:** Department of Human Services, 1350 S. King Street, Suite 200, Honolulu, HI 96814, **Phone:** 808-524-3370 (Oahu), 1-800-316-8005 (Neighbor Islands), **TTY:**711, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** medquest.hawaii.gov/
IA	**Iowa Medicaid**, **Address:** Iowa Department of Health and Human Services, 1305 E Walnut Street, Des Moines, IA 50319-0114, **Phone:** 1-800-338-8366, 515-256-4606, **TTY:** 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.iowa.gov/programs/welcome-iowa-medicaid
ID	**Idaho Medicaid**, **Address:** Idaho Department of Health and Welfare, PO Box 83720, Boise, ID 83720-0036, **Phone:** 1-888-528-5861, 1-877-456-1233, **TTY:** 1-888-791-3004 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** healthandwelfare.idaho.gov/services-programs/medicaid-health
IL	**Illinois Medicaid**, **Address:** Department of Healthcare and Family Services (HFS), Prescott Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763, **Phone:** 1-800-843-6154, 1-866-468-7543, **TTY:** 1-877-204-1012 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hfs.illinois.gov/about/about.html
IN	**Indiana Medicaid**, **Address:** Family and Social Services Administration, 402 W. Washington Street, Room W392, PO Box 7083, Indianapolis, IN 46204, **Phone:** 1-800-403-0864, 1-800-457-4584, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** in.gov/fssa/ompp/

	State Medicaid Office
KS	**KanCare (Kansas' Medicaid program)**, **Address:** KanCare Clearinghouse, PO Box 3599, Topeka, KS 66601, **Phone:** 1-800-792-4884, **TTY:** 711, 1-800-792-4292 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kancare.ks.gov/
KY	**Kentucky Medicaid**, **Address:** Cabinet for Health and Family Services (CHFS), 275 E. Main St., Frankfort, KY 40621, **Phone:** Member Services: 1-800-635-2570, Eligibility: 1-855-306-8959, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dms/Pages/default.aspx
LA	**Louisiana Medicaid**, **Address:** Louisiana Department of Health, PO Box 629, Baton Rouge, LA 70821-0629, **Phone:** 1-888-342-6207, **TTY:** 1-855-526-3346 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ldh.la.gov/page/about-medicaid
MA	**MassHealth (Massachusetts' Medicaid program)**, **Address:** One Ashburton Place, Boston, MA 02108, **Phone:** 1-800-841-2900, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mass.gov/orgs/masshealth
MD	**Maryland Medicaid**, **Address:** Department of Health, Herbert R. O'Conor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, **Phone:** 1-877-463-3464, 410-767-6500, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** mmcp.health.maryland.gov/Pages/home.aspx
ME	**MaineCare**, **Address:** Department of Health and Human Services, Office for Family Independence, 114 Corn Shop Lane, Farmington, ME 04938, **Phone:** 1-855-797-4357, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** maine.gov/dhhs/ofi/programs-services/health-care-assistance
MI	**Michigan Medicaid**, **Address:** Health & Human Services, 333 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, **Phone:** 1-800-642-3195, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** michigan.gov/medicaid
MN	**Medical Assistance (MA) (Minnesota's Medicaid program)**, **Address:** Department of Human Services, 540 Cedar Street, Saint Paul, MN 55101, **Phone:** 1-800-657-3739, 651-431-2670, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
MO	**Missouri Medicaid (MO HealthNet)**, **Address:** Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, **Phone:** 573-751-3425, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mydss.mo.gov/mhd
MP	**Northern Mariana Islands Medical Assistance for the Needy (MAN) Program**, **Address:** Commonwealth Medicaid Agency, Government Building No. 1252, Capitol Hill Rd., Caller Box 10007 Saipan MP 96950, **Phone:** 670-664-4880/82/86/87/88 (Eligibility), 670-664-4883/84 (Claims), **TTY:**711, **Hours:** Monday–Thursday 7:30 AM to 1:00 PM, Closed on Fridays and holidays, **Website:** http://medicaid.cnmi.mp/
MS	**Mississippi Division of Medicaid**, **Address:** MS Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201, **Phone:** 1-800-421-2408, 601-359-6050, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.ms.gov/

	State Medicaid Office
MT	**Montana Medicaid**, **Address:** Department of Public Health and Human Services (DPHHS), 111 North Sanders Street, Helena, MT 59601-4520, PO Box 4210, Helena, MT 59604-4210, **Phone:** 1-800-362-8312 (Member Help Line), 1-888-706-1535 (Eligibility), **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
NC	**NC Medicaid, Division of Health Benefits**, **Address:** 2501 Mail Service Center, Raleigh, NC 27699-2501, **Phone:** 1-888-245-0179, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.ncdhhs.gov/
ND	**North Dakota Medicaid**, **Address:** Medical Services Division, North Dakota Health and Human Services, 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250, **Phone:** 1-800-755-2604, 701-328-7068, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.nd.gov/healthcare/medicaid
NE	**Nebraska Medicaid**, **Address:** Department of Health and Human Services, 301 Centennial Mall South, Lincoln, NE 68509, **Phone:** 1-855-632-7633 (Eligibility), 402-471-3121 (Division of Medicaid), **TTY:** 1-402-471-7256 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx
NH	**New Hampshire Medicaid (Medical Assistance) program**, **Address:** Department of Health & Human Services, Division of Medicaid Services, 129 Pleasant Street, Concord, NH 03301, **Phone:** 1-844-275-3447, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhhs.nh.gov/programs-services/medicaid
NJ	**NJ Department of Human Services, Division of Medical Assistance & Health Services**, **Address:** NJ Department of Human Services, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, **Phone:** 1-800-701-0710, **TTY:**711, **Hours:** Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM, **Website:** state.nj.us/humanservices/dmahs/
NM	**Centennial Care (New Mexico's Medicaid program)**, **Address:** Human Services Department, PO Box 2348, Santa Fe, NM 87504-2348, **Phone:** 1-800-283-4465, **TTY:**711, **Hours:** Monday–Friday 7:00 AM to 5:00 PM, **Website:** hsd.state.nm.us/lookingforassistance/centennial-care-overview/
NV	**Nevada Medicaid**, **Address:** Department of Health and Human Services, PO Box 30042, Reno, NV 89520-3042, **Phone:** 1-877-638-3472, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.nv.gov
NY	**New York State Medicaid**, **Address:** New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, **Phone:** 1-800-541-2831, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 8:00 PM, Saturday 9:00 AM to 1:00 PM, **Website:** health.ny.gov/health_care/medicaid/
OH	**Ohio Medicaid**, **Address:** Ohio Department of Medicaid, 50 W. Town Street, Suite 400, Columbus, OH 43215, **Phone:** 1-800-324-8680, **TTY:**711, **Hours:** Monday–Friday 7:00 AM to 8:00 PM, Saturday 8:00 AM to 4:00 PM, **Website:** medicaid.ohio.gov/
OK	**SoonerCare**, **Address:** Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, **Phone:** 1-800-987-7767, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oklahoma.gov/ohca.html

	State Medicaid Office
OR	**Oregon Health Plan (OHP)**, **Address:** PO Box 14015, Salem, OR 97309, **Phone:** 1-800-273-0557, **TTY:**711, **Hours:** Monday–Friday 7:00 AM to 6:00 PM, **Website:** oregon.gov/oha/hsd/ohp/Pages/index.aspx
PA	**Medical Assistance (Pennsylvania's Medicaid program)**, **Address:** Department of Human Services, County Assistance Office (CAO), 801 Market Street, Philadelphia, PA 19107, **Phone:** 1-215-560-7226, **TTY:** 711 or 1-800-451-5886 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
PR	**Medicaid Program**, **Address:** Department Of Health, PO Box 70184, San Juan, PR 00936-8184, **Phone:** 787-641-4224, **TTY:** 787-625-6955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday-Friday 8:00 AM to 6:00 PM, **Website:** medicaid.pr.gov
RI	**Rhode Island Executive Office of Health and Human Services (EOHHS)**, **Address:** PO Box 8709, Cranston, RI 02920-8787, **Phone:** 1-855-697-4347, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 4:00 PM, **Website:** eohhs.ri.gov/consumer/health-care
SC	**Healthy Connections (South Carolina's Medicaid program)**, **Address:** Department of Health and Human Services (SCDHHS), PO Box 8206, Columbia, SC 29202-8206, **Phone:** 1-888-549-0820, **TTY:** 1-888-842-3620 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** scdhhs.gov/
SD	**South Dakota Medicaid**, **Address:** Department of Social Services, 700 Governors Drive, Pierre, SD 57501, **Phone:** 1-800-597-1603, 605-773-3165, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dss.sd.gov/medicaid/
TN	**TennCare Medicaid (Tennessee's Medicaid program)**, **Address:** 310 Great Circle Road, Nashville, TN 37243, **Phone:** 1-855-259-0701 (Applications), 1-800-342-3145 (General), **TTY:** 1-877-779-3103 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 6:00 PM, **Website:** tn.gov/tenncare
TX	**Texas Medicaid Program**, **Address:** Health and Human Services (HHS), North Austin Complex, 4601 W. Guadalupe St., Austin, TX 78751-3146, PO Box 13247, Austin, Texas 78711-3247, **Phone:** 1-800-252-8263, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/medicaid-chip
UT	**Utah Medicaid**, **Address:** Department of Health and Human Services, Cannon Health Building, 288 North 1460 West, Salt Lake City, UT 84116, **Phone:** 1-800-662-9651, 801-538-6155 (Customer Service); 801-526-0950, 1-866-435-7414 (Eligibility), **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM MST (Tuesday hours are 11:00 AM to 5:00 PM), **Website:** medicaid.utah.gov/
VA	**Virginia Medicaid**, **Address:** Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, **Phone:** 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), **TTY:** 1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, **Website:** dmas.virginia.gov/

	State Medicaid Office
VI	**Virgin Islands Medicaid Program**, **Address:** Department of Human Services, Knud Hansen Complex 1303 Hospital Ground Bldg. A, St. Thomas, VI 00802; 3011 Golden Rock, Christiansted, St. Croix, VI 00820, **Phone:** 340-715-6929 (Customer Support), 340-774-0930 (St. Thomas/St. John), 340-772-7100 (St. Croix), **TTY:**711, **Hours:** Monday–Friday 7:00 AM to 7:00 PM, **Website:** vimmis.com/default.aspx
VT	**Vermont Medicaid Programs**, **Address:** Agency of Human Services, Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, **Phone:** 1-800-250-8427, **TTY:**711, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** dvha.vermont.gov/members
WA	**Washington Apple Health**, **Address:** Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501, **Phone:** 1-800-562-3022, **TTY:**711, **Hours:** Monday–Friday 7:00 AM to 5:00 PM, **Website:** hca.wa.gov/
WI	**Wisconsin Medicaid**, **Address:** Department of Health Services, 1 West Wilson Street, Madison, WI 53703, **Phone:** 1-800-362-3002, 608-266-1865, **TTY:** 711 or 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** dhs.wisconsin.gov/medicaid/index.htm
WV	**West Virginia Medicaid program**, **Address:** Department of Health and Human Resources, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3709, **Phone:** 1-877-716-1212, 304-558-1700, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** dhhr.wv.gov/bms/Pages/default.aspx
WY	**Wyoming Medicaid**, **Address:** Wyoming Department of Health, Healthcare Financing Division, 122 W. 25th St., 4th Floor West, Cheyenne, WY 82002, **Phone:** 1-855-294-2127, 307-777-7531, **TTY:** 1-855-329-5204 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.wyo.gov/

	State Health Insurance Assistance Program (SHIP)
AK	**Alaska Medicare Information Office**, **Address:** Department of Health, 1835 Bragaw Street, Suite 350, Anchorage, AK 99508, **Phone:** 1-800-478-6065, 907-269-3680, **TTY:** 1-800-770-8973 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicare.alaska.gov
AL	**Alabama State Health Insurance Assistance Program**, **Address:** RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, **Phone:** 1-877-425-2243, 334-242-5743, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** alabamaageline.gov/ship/
AR	**Arkansas Seniors Health Insurance Information Program (AR SHIIP)**, **Address:** 1 Commerce Way, Little Rock, AR 72202, **Phone:** 1-800-224-6330, **TTY:** 501-683-4468 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** shiipar.com
AZ	**Arizona State Health Insurance Assistance Program**, **Address:** Department of Economic Security, Division of Aging and Adult Services, 1789 W. Jefferson Street, Phoenix, AZ 85007, **Phone:** 1-800-432-4040, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** des.az.gov/medicare-assistance
CA	**California Health Insurance Counseling and Advocacy Program (HICAP)**, **Address:** Department of Aging, 2880 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, **Phone:**

	State Health Insurance Assistance Program (SHIP)
	1-800-434-0222, **TTY:** 1-800-735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.ca.gov/hicap/
CO	**Colorado Senior Health Care & Medicare Assistance (SHIP & SMP)**, **Address:** Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202, **Phone:** 1-888-696-7213, 1-800-503-5190, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare
CT	**Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES)**, **Address:** Department of Aging and Disability Services, 55 Farmington Ave., 12th Floor, Hartford, CT 06105, **Phone:** 1-800-994-9422, **TTY:** 860-247-0775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** portal.ct.gov/ADS-CHOICES
DC	**Health Insurance Counseling Project (HICP)**, **Address:** Department of Aging and Community Living, 250 E Street SW, Washington, DC 20024, **Phone:** 202-727-8370, **TTY:**711, **Hours:** Monday–Friday 9:30 AM to 4:30 PM, **Website:** dacl.dc.gov/service/health-insurance-counseling
DE	**Delaware Medicare Assistance Bureau (DMAB)**, **Address:** Department of Insurance, 1351 West North Street, Suite 101, Dover, DE 19904, **Phone:** 1-800-336-9500, 302-674-7364, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 3:30 PM, **Website:** insurance.delaware.gov/divisions/dmab/
FL	**Serving Health Insurance Needs of Elders (SHINE) (Florida SHIP)**, **Address:** Department of Elder Affairs, 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, **Phone:** 1-800-963-5337, **TTY:** 1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridashine.org/
GA	**Georgia SHIP**, **Address:** Department of Human Services, Division of Aging Services, 229 Peachtree Street NE, Suite 100, Atlanta, GA 30303, **Phone:** 1-866-552-4464, Option 4, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.georgia.gov/georgia-ship
GU	**Guam State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Public Health and Social Services, Division of Senior Citizens, Guam Department of Public Health and Social Services, 123 Chalan Kareta, Mangilao, Guam 96913-6304, **Phone:** 671-735-7415, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphss.guam.gov
HI	**Hawaii SHIP**, **Address:** State Department of Health, Executive Office on Aging, No. 1 Capitol District, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, **Phone:** 1-888-875-9229, 808-586-7299, **TTY:**1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** hawaiiship.org/
IA	**Iowa Senior Health Insurance Information Program (SHIIP)**, **Address:** Insurance Division, 1963 Bell Ave., Suite 100, Des Moines, IA 50315, **Phone:** 1-800-351-4664, **TTY:** 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** shiip.iowa.gov/
ID	**Idaho Senior Health Insurance Benefits Advisors (SHIBA)**, **Address:** Department of

	State Health Insurance Assistance Program (SHIP)
	Insurance, 700 W. State Street, 3rd Floor, PO Box 83720, Boise, ID 83720-0043, **Phone:** 1-800-247-4422, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, except state holidays, **Website:** doi.idaho.gov/SHIBA/
IL	**Senior Health Insurance Program (Illinois SHIP)**, **Address:** Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, **Phone:** 1-800-252-8966, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** www2.illinois.gov/aging/ship/Pages/default.aspx
IN	**Indiana State Health Insurance Assistance Program**, **Address:** Department of Insurance, 311 W. Washington Street, Indianapolis, IN 46204, **Phone:** 1-800-452-4800, **TTY:** 1-866-846-0139 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** in.gov/ship/
KS	**Senior Health Insurance Counseling for Kansas (SHICK)**, **Address:** Department for Aging and Disability Services, New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, **Phone:** 1-800-860-5260, **TTY:** 785-291-3167 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick
KY	**Kentucky State Health Insurance Assistance Program**, **Address:** Cabinet for Health and Family Services, 275 E. Main Street, 3E-E, Frankfort, KY 40601, **Phone:** 1-877-293-7447 (Option 2), 502-564-6930, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dail/Pages/ship.aspx
LA	**Louisiana Senior Health Insurance Information Program (SHIIP)**, **Address:** Department of Insurance, 1702 N. Third Street, PO Box 94214, Baton Rouge, LA 70802, **Phone:** 1-800-259-5300, Option 2, 225-342-5301, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ldi.la.gov/consumers/senior-health-shiip
MA	**SHINE (Serving Health Insurance Needs of Everyone) (Massachusetts SHIP)**, **Address:** Executive Office of Elder Affairs, 1 Ashburton Place, 3rd Floor, Boston, MA 02108, **Phone:** 1-800-243-4636, **TTY:** 1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mass.gov/health-insurance-counseling
MD	**Maryland State Health Insurance Assistance Program**, **Address:** Department of Aging, 301 West Preston Street, Suite 1007, Baltimore, MD 21201, **Phone:** 1-800-243-3425, 410-767-1100, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.maryland.gov/Pages/state-health-insurance-program.aspx
ME	**Maine State Health Insurance Assistance Program**, **Address:** Department of Health and Human Services, Office of Aging and Disability Services, 11 State House Station, 41 Anthony Avenue, Augusta, ME 04333, **Phone:** 1-800-262-2232, 207-287-9200, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
MI	**Michigan Medicare Assistance Program (MMAP)**, **Address:** Department of Health & Human Services, 333 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, **Phone:** 1-800-803-7174, 1-800-975-7630, **TTY:**1-888-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM, **Website:** mmapinc.org/

	State Health Insurance Assistance Program (SHIP)
MN	**Minnesota's Senior LinkAge Line**, **Address:** Elmer L. Anderson Human Services, 540 Cedar Street, St. Paul, MN 55164, **Phone:** 1-800-333-2433, **TTY:** 1-800-627-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00AM to 4:30 PM, **Website:** mn.gov/senior-linkage-line/
MO	**Missouri SHIP**, **Address:** Department of Commerce & Insurance, 301 West High St., Room 530, PO Box 690, Jefferson City, MO 65102, **Phone:** 1-800-390-3330, **TTY:**711, **Hours:** Monday–Friday 9:00 AM to 4:00 PM, **Website:** missouriship.org
MS	**Mississippi State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Human Services, Division of Aging and Adult Services, 200 South Lamar St., Jackson, MS 39201, **Phone:** 1-844-822-4622, 601-709-0624, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mdhs.ms.gov/aging/finding-services-for-older-adults/
MT	**Montana State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Public Health and Human Services, Senior and Long Term Care Division, 1100 N Last Chance Gulch, 4th Floor, Helena MT 59601, **Phone:** 1-800-551-3191, 406-444-4077, **TTY:**1-800-833-8503 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/sltc/aging/ship
NC	**Medicare and Seniors' Health Insurance Information Program (SHIIP) (North Carolina SHIP)**, **Address:** Department of Insurance, 3200 Beechleaf Court, Raleigh NC 27604, **Phone:** 1-855-408-1212, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
ND	**North Dakota State Health Insurance Assistance Program (SHIP)**, **Address:** Insurance Department, 600 E. Boulevard Ave., 5th Floor, Bismarck, ND 58505-0320, **Phone:** 1-888-575-6611, 1-800-233-1737, **TTY:**1-800-366-6888 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Thursday 8:00 AM to 5:00 PM, Friday 8:00 AM to 12:00 PM, **Website:** insurance.nd.gov/shic-medicare
NE	**Nebraska SHIP**, **Address:** Department of Insurance, 1526 K Street, Suite 201, Lincoln, NE 68508, **Phone:** 1-800-234-7119, **TTY:** 1-800-833-7352 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** doi.nebraska.gov/ship-smp
NH	**ServiceLink (New Hampshire SHIP)**, **Address:** Department of Health & Human Services, Brown Building, 129 Pleasant Street, Concord, NH 03301, **Phone:** 1-866-634-9412, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** servicelink.nh.gov
NJ	**New Jersey State Health Insurance Assistance Program (SHIP)**, **Address:** State Health Insurance Assistance Program, PO Box 807, Trenton, NJ 08625, **Phone:** 1-800-792-8820, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** nj.gov/humanservices/doas/services/q-z/ship/index.shtml
NM	**New Mexico State Health Insurance Assistance Program (SHIP)**, **Address:** New Mexico Aging & Long-Term Services Department, 2550 Cerrillos Road, Santa Fe, NM 87505, **Phone:** 1-800-432-2080, **TTY:** 505-476-4937 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** aging.nm.gov

	State Health Insurance Assistance Program (SHIP)
NV	**Nevada State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Health & Human Services, Aging and Disability Services Division, 3416 Goni Road, Suite D-132, Carson City, NV 89706, **Phone:** 1-800-307-4444, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
NY	**Health Insurance Information, Counseling and Assistance (HIICAP)**, **Address:** 2 Empire State Plaza, 5th Floor, Albany, NY 12223, **Phone:** 1-800-701-0501, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.ny.gov/health-insurance-information-counseling-and-assistance
OH	**Ohio Senior Health Insurance Information Program (OSHIIP)**, **Address:** Department of Insurance, 50 W. Town Street, Third Floor, Suite 300, Columbus, OH 43215, **Phone:** 1-800-686-1578, 614-644-2658, **TTY:**711, **Hours:** Monday–Friday 7:30 AM to 5:00 PM, **Website:** insurance.ohio.gov/about-us/divisions/oshiip
OK	**Oklahoma Senior Health Insurance Counseling Program (SHIP)**, **Address:** Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105, **Phone:** 1-800-763-2828, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oid.ok.gov/consumers/information-for-seniors/
OR	**Oregon Senior Health Insurance Benefits Assistance (SHIBA)**, **Address:** Department of Human Services, 500 Summer St. NE, E-12, Salem, Oregon 97301, **Phone:** 1-800-722-4134, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** shiba.oregon.gov/
PA	**Pennsylvania Medicare Education and Decision Insight (PA MEDI)**, **Address:** Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, **Phone:** 1-800-783-7067, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx
PR	**Programa Estatal de Asistencia Sobre Seguros de Salud (SHIP: State Health Insurance Assistance Program)**, **Address:** Oficina del Procurador de las Personas de Edad Avanzada, Oficina Central, Avenida Ponce de León, Parada 16 Edificio 1064 tercer piso, Santurce (altos del edificio de Marshalls), San Juan, PR 00919-1179, **Phone:** 1-800-981-0056 (Mayaguez); 1-800-981-7735 (Ponce); 1-877-725-4300 (Saint John), **TTY:**787-919-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx
RI	**Rhode Island State Health Insurance Assistance Program (SHIP)**, **Address:** Office of Healthy Aging, 25 Howard Ave., Building 57, Cranston, RI 02920, **Phone:** 1-888-884-8721, **TTY:** 401-462-0740 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oha.ri.gov/Medicare
SC	**Insurance Counseling Assistance and Referrals for Elders (I-Care) Program (South Carolina SHIP)**, **Address:** Department on Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201, **Phone:** 1-800-868-9095, **TTY:**1-888-842-3620 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** getcaresc.com/guide/insurance-counseling-medicaremedicaid
SD	**Senior Health Information and Insurance Education (SHIINE) (South Dakota SHIP)**, **Address:** Department of Human Services, Division of Long Term Services and Support, 3800 E Hwy 34 - Hillsview Plaza, c/o 500 E. Capitol Avenue, Pierre, SD 57501, **Phone:** 1-800-536-8197 (Eastern SD), 1-877-331-4834 (Central SD), 1-877-286-9072 (Western SD),

	State Health Insurance Assistance Program (SHIP)
	TTY:711, **Hours:** Monday–Friday 9:00 AM to 4:30 PM, **Website:** dhs.sd.gov/en/understand-my-medicare
TN	**Tennessee State Health Insurance Assistance Program (SHIP)**, **Address:** Commission on Aging and Disability, Andrew Jackson Bldg., 9th Floor, 502 Deaderick Street, Nashville, TN 37243, **Phone:** 1-877-801-0044, **TTY:** 1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tnmedicarehelp.com/
TX	**Texas Health Information, Counseling and Advocacy Program (HICAP)**, **Address:** Texas Health and Human Services Commission, Mail Code W358, PO Box 149030, Austin, Texas 78714-9030, **Phone:** 1-800-252-9240, 1-855-937-2372, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/medicare
UT	**Utah Senior Health Insurance Information Program (SHIP)**, **Address:** Department of Health & Human Services, Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah 84116, **Phone:** 1-800-541-7735, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** daas.utah.gov/seniors/
VA	**Virginia Insurance Counseling and Assistance Program (VICAP)**, **Address:** Division for Aging Services, 1610 Forest Ave., Suite 100, Henrico, VA 23229, **Phone:** 1-800-552-3402, 804-662-9333, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** vda.virginia.gov/vicap.htm
VI	**Virgin Islands State Health Insurance Assistance Program (VISHIP)**, **Address:** Office of the Lieutenant Governor, 1131 King Street, Suite 101, Christiansted, St. Croix, Virgin Islands 00820 (St. Croix); 5049 Kongens Gade, St. Thomas, Virgin Islands 00802 (St. Thomas/St. John), **Phone:** 340-773-6449 (St. Croix), 340-774-2991 (St. Thomas/St. John), **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** https://ltg.gov.vi/departments/vi-ship-medicare/
VT	**Vermont State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Disabilities, Aging and Independent Living, Adult Services Division, 280 State Drive, HC2 South, Waterbury, VT 05671-2070, **Phone:** 1-800-642-5119, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** asd.vermont.gov/services/ship
WA	**Washington Statewide Health Insurance Benefits Advisors (SHIBA)**, **Address:** Office of the Insurance Commissioner, PO Box 40255, Olympia, WA 98504-0255, **Phone:** 1-800-562-6900, **TTY:** 360-586-0241 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba
WI	**Wisconsin State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Health Services, 1 W. Wilson Street, Madison, WI 53703, **Phone:** 1-800-242-1060, **TTY:** 711 or 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
WV	**West Virginia State Health Insurance Assistance Program (WV SHIP)**, **Address:** Bureau of Senior Services, 1900 Kanawha Blvd. East, (3rd Floor Town Center Mall) Charleston, WV 25305, **Phone:** 1-877-987-4463, 304-558-3317, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** wvship.org/
WY	**Wyoming State Health Insurance Information Program (WSHIIP)**, **Address:** 106 W. Adams Ave., Riverton, WY 82501, **Phone:** 1-800-856-4398, **TTY:**711, **Hours:** Monday–Friday 7:00 AM

	State Health Insurance Assistance Program (SHIP)
	to 4:00 PM, **Website:** wyomingseniors.com/

	State Pharmaceutical Assistance Program (SPAP)
AL	**Alabama SenioRx Prescription Assistance Program**, **Address:** Department of Senior Services, RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, **Phone:** 1-877-425-2243, 334-242-5743, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** alabamaageline.gov/seniorx/
DE	**Delaware Prescription Assistance Program**, **Address:** DXC DPAP, PO Box 950, New Castle, DE 19720-0950, **Phone:** 1-844-245-9580, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dhss/dmma/dpap.html
DE	**Delaware Chronic Renal Disease Program**, **Address:** 253 NE Front Street, Milford, DE 19963, **Phone:** 302-424-7180, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dhss/dmma/crdprog.html
IN	**HoosierRx**, **Address:** 402 W. Washington, Room 372, Indianapolis, IN 46204, **Phone:** 1-866-267-4679, **TTY:**711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** IN.gov/HoosierRx
KY	**Kentucky Prescription Assistance Program (KPAP)**, **Address:** 275 East Main Street, HS2W-B, Frankfort, KY 40621, **Phone:** 1-800-633-8100, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** chfs.ky.gov/agencies/dph/dpqi/hcab/Pages/kpap.aspx
MA	**Prescription Advantage**, **Address:** PO Box 15153, Worcester, MA 01615-0153, **Phone:** 1-800-243-4636, **TTY:**1-877-610-0241 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mass.gov/prescription-drug-assistance
MD	**Maryland Senior Prescription Drug Assistance Program (SPDAP)**, **Address:** Maryland – SPDAP c/o International Software Systems Inc., PO Box 749, Greenbelt, Maryland 20768-0749, **Phone:** 1-800-551-5995, **TTY:**1-800-877-5156 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** marylandspdap.com/
ME	**MaineCare Rx Plus**, **Address:** Office of Family Independence, State of Maine - DHHS, 114 Corn Shop Lane, Farmington, ME 04938-9900, **Phone:** 1-866-796-2463, **TTY:**711, **Hours:** Monday–Friday 7:00 AM to 4:00 PM, **Website:** maine.gov/dhhs/oms/member-resources/pharmacy-benefits
MO	**Missouri Rx Plan (MORx)**, **Address:** PO Box 2700, Jefferson City, MO 65102, **Phone:** 1-800-375-1406, 573-751-6963, **TTY:**1-800-735-2966 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 6:00 AM to 6:00 PM, **Website:** dss.mo.gov/mhd/faq/pages/faqmo_rx.htm
MT	**Montana Big Sky Rx Program**, **Address:** PO Box 202915, Helena, MT 59620-2915, **Phone:** 1-866-369-1233, 406-444-1233, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** BigSkyRx.MT.gov
NJ	**New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD)**, **Address:** PAAD-HAAAD, Department of Human Services, PO Box 715, Trenton, NJ 08625-0715, **Phone:** 1-800-792-9745, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nj.gov/humanservices/doas/services/l-p/paad/

	State Pharmaceutical Assistance Program (SPAP)
NJ	**New Jersey Senior Gold Prescription Discount Program**, **Address:** Division of Aging Services, PO Box 715, Trenton, NJ 08625-0715, **Phone:** 1-800-792-9745, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nj.gov/humanservices/doas/services/q-z/senior-gold/
NM	**New Mexico Medical Insurance Pool (NMMIP)**, **Address:** PO 780548, San Antonio, TX 78278, **Phone:** 1-866-306-1882, **TTY:**1-844-728-7987 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nmmip.org
OK	**RX for Oklahoma**, **Address:** Oklahoma Department of Commerce, 900 N. Stiles Ave., Oklahoma City, OK 73104, **Phone:** 1-877-794-6552, 405-243-2939, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** okcommerce.gov/rx-for-oklahoma-prescription-assistance/
PA	**Pharmaceutical Assistance Contract for the Elderly (PACE)/PACE Needs Enhancement Tier (PACENET)**, **Address:** PACE/PACENET, PO Box 8806, Harrisburg, PA 17105-8806, **Phone:** 1-800-225-7223, **TTY:**1-800-222-9004 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
PA	**Special Pharmaceutical Benefits Program - Mental Health, Address:** Department of Human Services - OMHSAS, Business Partner Support Unit - SPBP-MH Program, Commonwealth Tower, 12th Floor, PO Box 2675, Harrisburg, PA 17105-2675, **Phone:** 1-877-356-5355, Option 3, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Special-Pharm-Benefits-Program.aspx
PA	**Chronic Renal Disease Program (CRDP)**, **Address:** The Chronic Renal Disease Program, Pennsylvania Department of Health, Division of Child and Adult Health Services, 625 Forster St., 7th Floor East Wing, Harrisburg, PA 17120-0701, **Phone:** 1-800-225-7223, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** health.pa.gov/topics/programs/Chronic-Renal-Disease
RI	**RI Pharmaceutical Assistance to Elders (RIPAE)**, **Address:** RI Office of Health Aging, 25 Howard Avenue, Louis Pasteur Bldg., #57 Cranston, RI 02920, **Phone:** 401-462-3000, 401-462-0560, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance
TX	**Kidney Health Care Program (KHC)**, **Address:** Kidney Health Care, MC 1938, PO Box 149030, Austin, TX 78714-9947, **Phone:** 1-800-222-3986, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/kidney-health-care
VI	**VI State Pharmaceutical Assistance Program**, **Address:** St. Thomas Office, 1303 Hospital Ground, Knud Hansen Complex / Building A, St. Thomas, VI 00802, St. Croix Office, 3011 Golden Rock, Christiansted, St Croix, VI 00820, St. John Office, DHS Head Quarters in St. John, Cruz Bay, St. John, **Phone:** St Thomas: 340-774-0930, St. Croix: 340-773-2323, St. John: 340-776-6334, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhs.gov.vi/index.php/senior-citizen-affairs/
VT	**VPharm and Healthy Vermonters Programs**, **Address:** Green Mountain Care, Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500, **Phone:** 1-800-250-8427, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** dvha.vermont.gov/members/prescription-assistance

	State Pharmaceutical Assistance Program (SPAP)
WI	**SeniorCare**, **Address:** Senior Care, PO Box 6710, Madison, WI 53716-0710, **Phone:** 1-800-657-2038, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** dhs.wisconsin.gov/seniorcare/index.htm

	State AIDS Drug Assistance Programs (ADAP)
AK	**Alaska AIDS Drug Assistance Program (ADAP)**, **Address:** Anchorage – 1057 W. Fireweed Lane, Suite 102, Anchorage, AK 99503 Juneau – 225 Front Street, Suite 103-A, Juneau, AK 99801, **Phone:** 1-800-478-AIDS (2437), Anchorage: 907-263-2050, Juneau: 907-500-7465, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** alaskanaids.org/client-services/aids-drug-assistance-program-adap
AL	**Alabama AIDS Drug Assistance Program (ADAP)**, **Address:** Office of HIV Prevention and Care, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104, **Phone:** 1-866-574-9964, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** alabamapublichealth.gov/hiv/adap.html
AR	**Ryan White Program, Arkansas AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 4815 W. Markham, Little Rock, AR 72205, **Phone:** 1-800-462-0599, Option 3, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** healthy.arkansas.gov/programs-services/topics/ryan-white-program
AS	**Ryan White AIDS Drug Assistance Program**, **Address:** Department of Public Health, LBJ Tropical Medical Center, PO Box F, Pago Pago, AS 96799, **Phone:** 202-434-8090, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** adap.directory/american-samoa
AZ	**Arizona AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health Services, 150 N. 18th Ave., Suite 280, Phoenix, AZ 85007, **Phone:** 602-542-1025, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** azadap.com
CA	**California AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, Office of AIDS, MS 7700, PO Box 997426, Sacramento, CA 95899-7426, **Phone:** 1-844-421-7050, 916-558-1784, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** cdph.ca.gov/Programs/CID/DOA/pages/oaadap.aspx
CO	**Colorado State Drug Assistance Program (SDAP)**, **Address:** Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, CO 80246, **Phone:** 303-692-2716, **TTY:**711, **Hours:** Monday–Friday 7:30 AM to 5:15 PM, **Website:** cdphe.colorado.gov/state-drug-assistance-program
CT	**Connecticut AIDS Drug Assistance Program (CADAP)**, **Address:** Department of Public Health c/o Magellan Rx Management, PO Box 13001, Albany, NY 12212-3001, **Phone:** 1-800-424-3310, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ctdph.magellanrx.com/
DC	**DC AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 2201 Shannon Place SE, Washington, DC 20020, **Phone:** 202-671-4815, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:30 PM, **Website:** dchealth.dc.gov/DC-ADAP
DE	**Delaware AIDS Drug Assistance Program (ADAP)**, **Address:** Division of Public Health (DPH), Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901, **Phone:** 302-744-1050, Option 1, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dph/dpc/hivtreatment.html
FL	**Florida AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, HIV/AIDS

	State AIDS Drug Assistance Programs (ADAP)
	Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, **Phone:** 1-800-352-2437, 844-381-2327, 850-245-4422, **TTY:** 1-888-503-7118 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridahealth.gov/diseases-and-conditions/aids/adap/
GA	**Georgia AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, 200 Piedmont Avenue, SE, Atlanta, GA 30334, **Phone:** 404-656-9805, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dph.georgia.gov/health-topics/office-hivaids/hiv-care/aids-drug-assistance-program-adap
GU	**Guam Medicaid**, **Address:** Department of Public Health & Social Services, 761 South Marine Corps Drive, Tamuning, GU 96913, **Phone:** 671-300-7330, **TTY:**711, **Hours:** 8:00 AM to 4:00 PM, **Website:** dphss.guam.gov
HI	**Hawaii HIV Drug Assistance Program (HDAP)**, **Address:** State Department of Health, 3627 Kilauea Ave., Suite 306, Honolulu, HI 96816, **Phone:** 808-733-9362, 808-733-9361, **TTY:**711, **Hours:** Monday–Friday 7:45 AM to 2:30 PM, **Website:** health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/
IA	**Iowa AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, 321 E. 12th Street, Des Moines, IA 50319-0075, **Phone:** 515-204-3746, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** hhs.iowa.gov/public-health/sexually-transmitted-infections/hivaids-program
ID	**Idaho AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Welfare, Division of Public Health, 450 W. State Street, PO Box 83720, Boise, ID 83702, **Phone:** 208-334-5612, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv
IL	**Illinois AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, Medication Assistance Program,525 W. Jefferson Street, 1st Floor, Springfield, IL 62761, **Phone:** 1-800-825-3518, **TTY:**711, **Hours:** Monday–Friday 9:00 AM to 4:00 PM, **Website:** dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services
IN	**Indiana AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 2 N. Meridian Street, Suite C, Indianapolis, IN 46204, **Phone:** 1-866-588-4948, Option 1, **TTY:**711, **Hours:** Monday–Friday 8:15 AM to 4:45 PM, **Website:** in.gov/health/hiv-std-viral-hepatitis/hiv-services/
KS	**Kansas AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Environment, Division of Public Health, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, **Phone:** 785-296-6174, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kdhe.ks.gov/359/AIDS-Drug-Assistance-Program-ADAP
KY	**Kentucky AIDS Drug Assistance Program (KADAP)**, **Address:** Department of Public Health, 275 East Main Street, HS2E-C, Frankfort, KY 40621, **Phone:** 1-800-420-7431, 502-564-6539, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dph/dehp/hab/pages/services.aspx
LA	**Louisiana AIDS Drug Assistance Program**, **Address:** Department of Health, 1450 Poydras Street, Suite 2136, New Orleans, LA 70112, **Phone:** 504-568-7474, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** lahap.org/

	State AIDS Drug Assistance Programs (ADAP)
MA	**Massachusetts HIV/AIDS Drug Assistance Program (HDAP)**, **Address:** Community Resource Initiative, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129, **Phone:** 1-800-228-2714, 617-502-1700, Option 1, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** crihealth.org/drug-assistance/hdap/
MD	**Maryland AIDS Drug Assistance Program (MADAP)**, **Address:** Department of Health, 1223 W. Pratt Street, Baltimore, MD 21223, **Phone:** 1-800-205-6308, 410-767-6536, **TTY:** 1-800-735-2258 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
ME	**Maine AIDS Drug Assistance Program (ADAP)**, **Address:** 286 Water Street, 11 State House Station, Augusta ME 04330, **Phone:** 207-287-5199, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml
MI	**Michigan Drug Assistance Program (MIDAP)**, **Address:** Department of Health and Human Services, PO Box 30727 Lansing, MI 48909, **Phone:** 1-888-826-6565, **TTY:**711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** michigan.gov/dap
MN	**Minnesota Aids Drug Assistance Program**, **Address:** Minnesota Department of Human Services, PO Box 64972, St. Paul, MN 55164-0972, **Phone:** 1-800-657-3761, 651-431-2398, **TTY:**711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/
MO	**Missouri AIDS Drug Assistance Program**, **Address:** Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102, **Phone:** 573-751-6439, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
MP	**Ryan White HIV/AIDS Program**, **Address:** CNMI Department of Public Health, PO Box 500409, Saipan, MP 96950, **Phone:** 670-234-8950, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** chcc.health/
MS	**Mississippi AIDS Drug Assistance Program (ADAP)**, **Address:** State Department of Health, PO Box 1700, Jackson, MS 39215, **Phone:** 1-888-343-7373, 601-362-4879, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** msdh.ms.gov/msdhsite/_static/14,13047,150.html
MT	**Montana AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health and Human Services, Cogswell Building, Room C-211, 1400 Broadway, Helena, MT 59620, **Phone:** 406-444-3565, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
NC	**North Carolina HIV Medication Assistance Program (NC HMAP)**, **Address:** Department of Health and Human Services, 1907 Mail Service Center, Raleigh, NC 27699-1907, **Phone:** 1-877-466-2232, 919-733-9161, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** epi.dph.ncdhhs.gov/cd/hiv/hmap.html
ND	**North Dakota AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Human Services, 600 East Boulevard Ave, Bismarck, ND 58505-0250, **Phone:** 1-800-472-2622, 701-328-2310, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.nd.gov/health/diseases-conditions-and-immunization/north-dakota-ryan-white-part-b-program
NE	**Nebraska AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health &

	State AIDS Drug Assistance Programs (ADAP)
	Human Services, PO Box 95026, Lincoln, NE 68509-5026, **Phone:** 402-471-2101, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhs.ne.gov/Pages/HIV-Care.aspx
NH	**New Hampshire AIDS Drug Assistance Program**, **Address:** Department of Health & Human Services, 29 Hazen Drive, Concord, NH 03301, **Phone:** 603-271-4502, 603-271-4496, **TTY:** 1-800-735-2964This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap
NJ	**New Jersey AIDS Drug Distribution Program (ADDP)**, **Address:** PO Box 722, Trenton, NJ 08625-0722, **Phone:** 1-877-613-4533, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nj.gov/health/hivstdtb/hiv-aids/medications.shtml
NM	**New Mexico AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 5300 Homestead NE, Suite 110, Albuquerque, NM 87110, **Phone:** 505-709-7618, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nmhealth.org/about/phd/idb/hats/
NV	**Nevada AIDS Drug Assistance Program (ADAP)/Nevada Medication Assistance Program (NMAP)**, **Address:** Department of Health and Human Services, 2290 S. Jones Blvd., Las Vegas, Nevada 89146, **Phone:** 702-486-0768, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** endhivnevada.org/adap-nmap/
NY	**New York AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, Uninsured Care Programs, Empire Station, PO Box 2052, Albany, NY 12220-0052, **Phone:** 1-800-542-2437, 1-844-682-4058, 518-459-1641, **TTY:** 518-459-0121 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.ny.gov/diseases/aids/general/resources/adap/
OH	**Ohio HIV Drug Assistance Program (OHDAP)**, **Address:** Department of Health, 246 N. High Street, Columbus, OH 43215, **Phone:** 1-800-777-4775, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
OK	**Oklahoma AIDS Drug Assistance Program (ADAP)**, **Address:** State Department of Health, 123 Robert S. Kerr Avenue, Suite 1702, Oklahoma City, OK 73102-6406, **Phone:** 405-426-8400, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.html
OR	**Oregon AIDS Drug Assistance Program (CAREAssist)**, **Address:** Oregon Health Authority, 800 NE Oregon Street, Suite 1105, Portland, OR 97232, **Phone:** 971-673-0144, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oregon.gov/oha/PH/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
PA	**Pennsylvania Special Pharmaceutical Benefits Program (SPBP)**, **Address:** Department of Health, Special Pharmaceutical Benefits Program, PO Box 8808, Harrisburg, PA 17105-8808, **Phone:** 1-800-922-9384, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
PR	**Ryan White Part B/ADAP Program**, **Address:** Departamento de Salud, OCASET, Programa Ryan White Parte B, PO Box 70184, San Juan, PR 00936-8184, **Phone:** 787-765-2929 Ext. 5106-5137, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:**

	State AIDS Drug Assistance Programs (ADAP)
	salud.pr.gov/CMS/137
RI	**Rhode Island AIDS Drug Assistance Program (ADAP)**, **Address:** Executive Office of Health & Human Services, 3 West Rd., Cranston, RI 02920, **Phone:** 401-462-3294, 401-462-3295, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx
SC	**South Carolina AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, **Phone:** 1-800-856-9954, 1-800-322-2437, **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** scdhec.gov/aids-drug-assistance-program
SD	**South Dakota AIDS Drug Assistance Program (ADAP)**, **Address:** Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th Street, Pierre, SD 57501-1700, **Phone:** 1-800-592-1861, 605-773-3737, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** doh.sd.gov/topics/diseases-conditions/communicable-infectious-diseases/reportable-communicable-diseases/hivaids/ryan-white-part-b-program/
TN	**Tennessee AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 710 James Robertson Parkway, Nashville, TN 37243, **Phone:** 615-340-5671, 615-253-3937, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
TX	**Texas HIV Medication Program (THMP)**, **Address:** Texas Health and Human Services, ATTN: MSJA, MC 1873, PO Box 149347, Austin, TX 78714-9347, **Phone:** 1-800-255-1090, 737-255-4300, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dshs.state.tx.us/hivstd/meds/default.shtm
UT	**Utah AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Human Services, 288 N 1460 West, PO Box 142104, Salt Lake City, UT 84114-2104, **Phone:** 801-538-6197, 801-538-6191, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** epi.utah.gov/ryan-white/
VA	**Virginia Medication Assistance Program (VA MAP)**, **Address:** Department of Health, 109 Governor Street, Richmond, VA 23219, **Phone:** 1-855-362-0658, 1-800-533-4148, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** vdh.virginia.gov/disease-prevention/vamap/
VI	**Ryan White HIV/AIDS Program**, **Address:** John Moorehead Complex (Old Hospital), Communicable Diseases Clinic, Building I, St. Thomas, VI 00802, **Phone:** 340-774-9000, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** doh.vi.gov/programs/communicable-diseases/
VT	**Vermont Medication Assistance Program (VMAP)**, **Address:** 108 Cherry Street, PO Box 70, Burlington, VT 05402-0070, **Phone:** 802-951-4005, 1-800-464-4343, **TTY:**711, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** healthvermont.gov/immunizations-infectious-disease/hiv/care
WA	**Washington Early Intervention Program (EIP)**, **Address:** State Department of Health, Client Services, PO Box 47841, Olympia, WA 98504-7841, **Phone:** 1-877-376-9316, 360-236-3426, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, except state holidays, **Website:** doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP
WI	**Wisconsin AIDS/HIV Drug Assistance Program (ADAP)**, **Address:** Department of Health Services, 1 West Wilson Street, Madison, WI 53703, **Phone:** 1-800-991-5532, **TTY:** 711 or 1-800-947-3529 This number requires special telephone equipment and is only for people

	State AIDS Drug Assistance Programs (ADAP)
	who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhs.wisconsin.gov/hiv/adap.htm
WV	**West Virginia AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health & Human Resources, PO Box 6360, Wheeling, WV 26003, **Phone:** 304-232-6822, **TTY:**711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** oeps.wv.gov/rwp/pages/default.aspx
WY	**Wyoming AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 401 Hathaway Building, Cheyenne, WY 82002, **Phone:** 307-777-5856 (HIV Treatment Program Manager), 307-777-6563 (ADAP Coordinator), **TTY:**711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** health.wyo.gov/publichealth/communicable-disease-unit/hiv/resources-for-patients/

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State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. You will find contact information for the SHIP in your state in the Appendix of this document.

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