SilverScript®

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

STRS OHIO HealthCare PROGRAM

January 1, 2024 - December 31, 2024

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of SilverScript Employer PDP sponsored by STRS Ohio (SilverScript) for retired teachers and family members.

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

For questions about this document, please contact Customer Care at 1-800-756-6859. (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. When it says "member" throughout SilverScript documents, it means enrollee.

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, 2025.

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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2024 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 under an STRS Ohio Medicare 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, 2024, and December 31, 2024.

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, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve 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:

- STRS Ohio 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.

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

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 2024 *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 *Formulary (List of Covered Drugs)*. 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. The Drug List we provide to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should contact Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can view your formulary online at **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)

Please contact STRS Ohio for more information about the premium for this plan.

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

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

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

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

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called "2024 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan Premium

Please contact STRS Ohio 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.

STRS Ohio does not require you to have a Part A plan if there is a cost associated.

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.

If you are required to pay a Part D late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible.

If you have a Part D late enrollment penalty, you will receive a monthly invoice from SilverScript. If you do not pay the monthly Part D late enrollment penalty premium, you could be disenrolled for failure to pay your plan premium. Therefore, to avoid disenrollment, make sure your Part D late enrollment penalty is paid.

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

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

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you 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 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $34.70, which equals $4.86. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

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

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D 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 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 November, and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses 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'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. Please also contact STRS Ohio for any changes in address, phone number, or name by calling 1-888-227-7877, Monday through Friday, 8a.m. to 5p.m., EST (TTY:711).

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 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	1-800-756-6859 Calls to this number are free, 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-888-472-1129
WRITE	SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330

How to contact us when you are asking for a coverage decision or 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	1-800-756-6859 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	1-800-756-6859 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. You can also use the website to tell Medicare about any complaints you have about SilverScript.

Medicare – Contact Information

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

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare 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, from 8 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See 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 1-800-756-6859. 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 coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums, and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

AIDS Drug Assistance Programs

An AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are 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.

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.

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) get benefits from your (or your spouse's) employer or retiree group as part of this plan sponsored by STRS Ohio, you may call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are printed on the back cover of this 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'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 2024* 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.
- In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies or through CVS Caremark Mail Service Pharmacy. See Section 2.5 of this chapter.
- Your prescription drugs on the plan's *Formulary (List of Covered Drugs)* (we call it the "Drug List" for short) are covered by the Medicare Part D portion of your benefit. See Section 3 of this chapter, *Your prescription drugs on the plan's "Drug List" are covered by the Medicare Part D portion of your benefit.*
    - **Please note:** The "Drug List" does not include any drugs covered by the additional coverage provided by STRS Ohio.
- Your prescription drug must be used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain references. See Section 3 of this chapter for more information about a medically accepted indication.

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 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 (https://info.caremark.com/oe/strsegwpretiree), and/or call Customer Care.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing (see paragraph below), 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 STRS Ohio, you may be able to save on your maintenance prescription drugs by changing your 31-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 31-day supplies. However, you may save by changing your 31-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 31-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 STRS Ohio, 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. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* 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 31-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 from the date the prescription is approved for processing. 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 at 1-800-756-6859.

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* 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 will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover 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 prescription drugs on the plan's "Drug List" are covered by the Medicare Part D portion of your benefit

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

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

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

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

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

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

The additional drug coverage provided by STRS Ohio, which is called your "Non-Part D Supplemental Benefit," covers certain prescription drugs not covered under Medicare Part D. Payments made for these prescription drugs will not count toward your initial coverage limit or total out-of-pocket costs. These prescription drugs are not subject to the appeals and exceptions process. The following categories are included in your Non-Part D Supplemental Benefit:

- Cough and Cold
- Erectile Dysfunction
- Vitamins and Minerals
- Weight Loss

To find out which drugs our plan covers, you can view the Non-Part D Supplemental Benefit document online at SilverScriptEmployerPDP.MemberDoc.com.

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

The Drug List includes brand name drugs, generic drugs, and biosimilars.

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs. There are biosimilar alternatives for some biological products.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

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

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*).

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

You have three ways to find out:

1. Check the most recent Drug List we provided for information on your drug coverage. (Please note: The Drug List we provide includes information for the covered prescription drugs that are most commonly used by our members. However, we may cover additional prescription drugs that are not included in the provided Drug List. If one of your prescription drugs is not listed on the Drug List, you should contact Customer Care to find out if we cover it.)
2. Call Customer Care to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
3. Use the plan's Real-Time Benefit Tool (https://info.caremark.com/oe/strsegwpretiree) 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).

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.)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for you or has written: "No substitutions" on your prescription for a brand name drug or original biological product or has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

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

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

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

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

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 90-day supply. If your prescription is written for fewer than 90 days, we will allow multiple fills to provide up to a maximum of a 90-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 prescription drug

If your drug is not covered, you may talk with your provider. Perhaps 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 prescription drugs that treat the same medical condition. This list can help your provider find a covered prescription 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 prescription drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the prescription drug without restrictions.

If you are a current member and a prescription drug you are taking will be removed from the formulary or restricted in some way for next year, we will 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 prescription drug

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

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 brand 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. Also, if there are drugs included under a Non-Part D Supplemental Benefit they are not eligible for a tiering exception. Non-Part D Supplemental coverage is offered by some former employer/union/trust plans to cover some prescription drugs not normally covered in a Medicare prescription drug plan. These are identified in Chapter 3, Section 3.1 of this document.

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

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.**

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

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online drug pricing tool on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

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

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
    - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
    - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.
    - After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
    - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7.

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

We may make certain changes to the Drug List that are not described above. In these cases, the 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 above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

Section 7.1 Types of prescription drugs we do not cover

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

If you get prescription drugs that are excluded by Medicare Part D, you must pay for them yourself, except for certain excluded drugs covered through the Non-Part D Supplemental Benefit coverage provided by STRS Ohio. 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 general rules about prescription drugs that Medicare prescription drug plans will not cover under Part D:

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

In addition, by law, the following categories of prescription drugs are not covered by Medicare prescription 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 Non-Part D Supplemental Benefit provided by STRS Ohio 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 7 of this document.)

In addition, if you **receive "Extra Help"** to pay for your prescriptions, the "Extra Help" program will not pay for the prescription 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 prescription drug plan. Please contact your state Medicaid program to determine what prescription drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in 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 STRS Ohio. 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 prescription drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer 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?

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

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

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

In general, if you have 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 STRS Ohio, 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 prescription drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct prescription 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
- Prescription drugs that may not be necessary because you are taking another prescription drug to treat the same condition

- Prescription drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of prescription drugs that could harm you if taken at the same time
- Prescriptions 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 doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

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

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

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

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

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

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you 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.

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 a Non-Part D Supplemental Benefit. Please refer to Chapter 3 to find more information about the type of coverage you have with STRS Ohio.

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 https://info.caremark.com/oe/strsegwpretiree 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 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.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

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

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3):

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

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

Any payments you made during this 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, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

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

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the calendar year, you will move 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 STRS Ohio but not normally covered in a Medicare prescription drug plan.

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

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

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

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

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

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan 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 $8,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.

After you reach your STRS Ohio individual maximum out-of-pocket costs of $4,000, STRS Ohio will pay the rest of your annual drug costs, including the cost share for any Non-Part D Supplemental Benefit drugs.

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 four 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 $4,000, STRS Ohio will pay the rest of your annual drug costs.

Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

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

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

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

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

If you have had one or more prescriptions filled through 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 that may be available.
- **Any additional prescription drug coverage you receive from STRS Ohio 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 most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call 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 During the Deductible Stage, you pay the full cost of your drugs

The Deductible Stage is the first payment stage for your prescription drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's annual deductible amount, which is $275.00 for 2024. The deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.

The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $275.00 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

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

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

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs and you pay your share 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 Drug

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, even if you haven't paid your deductible.

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*.

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.

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 31-day supply available at **any** network pharmacy)	**Mail-Order Pharmacy** (Up to a 31-day supply)	**Long-Term Care (LTC) Pharmacy** (Up to a 31-day supply)
Tier 1: Generic	$10.00	$25.00	$10.00
Tier 2: Preferred Brand	$30.00	$75.00	$30.00
Tier 3: Non-Preferred Drug	$75.00	$187.50	$75.00
Tier 4: Specialty (High Cost)	8% of total cost Maximum $450.00	8% of total cost Maximum $450.00	8% of total cost Maximum $450.00

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 31-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, even if you haven't paid your deductible.

Please see Section 9 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	$25.00	$30.00	$25.00
Tier 2: Preferred Brand	$75.00	$90.00	$75.00
Tier 3: Non-Preferred Drug	$187.50	$225.00	$187.50
Tier 4: Specialty (High Cost)	8% of total cost Maximum $1,350.00	8% of total cost Maximum $1,350.00	8% of total cost Maximum $1,350.00

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, even if you haven't paid your deductible.

Through the additional coverage provided by STRS Ohio, you may be able to save on your maintenance prescription drugs by changing your 31-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 31-day supplies. However, you may save by changing your 31-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 31-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 STRS Ohio, 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 $8,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $8,000. You then move on to the Catastrophic Coverage Stage. See section 8.1 below for more information on your STRS Ohio Annual Maximum Out-of-Pocket (MOOP).

STRS Ohio provides additional coverage on some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count toward your initial coverage limit or Medicare Part D total out-of-pocket costs. To find out which drugs our plan covers, please call Customer Care.

The 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. Many people do not reach the $8,000 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.

SECTION 6 Costs in the Coverage Gap Stage

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

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

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 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 stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

For excluded drugs covered under the additional coverage provided by STRS Ohio, you'll continue to pay the same cost sharing amount, during the Catastrophic Coverage stage. To find out the cost of your drug, use our online drug lookup tool within Caremark.com or call Customer Care at the number on your member ID card.

SECTION 8 STRS Ohio Annual Maximum Out-of-Pocket (MOOP)

Section 8.1 STRS Ohio 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 $4,000, STRS Ohio will pay the rest of your annual drug costs, including the cost share for any Non-Part D Supplemental Benefit drugs.

STRS Ohio provides additional coverage for some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count toward your initial coverage limit or Medicare Part D total out-of-pocket costs; however, your cost share for these drugs will apply to the maximum out-of-pocket (MOOP). To find out which drugs our plan covers, please call Customer Care.

SECTION 9 Part D vaccines. What you pay for depends on how and where you get them

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

For most adult Part D vaccines, you will pay nothing.

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.

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

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

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

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

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

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

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

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (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. 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 prescription 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. 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 prescription 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 STRS Ohio, 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 a late enrollment penalty, you must pay the penalty to remain a member of our plan.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, STRS Ohio and SilverScript 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 the United States or it's territories,** 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.

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

Is your problem or concern about your benefits or coverage?

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 your plan will 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. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 5 of this 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. (information listed in the appendix of this document).
- **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 begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

Your benefits 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 prescription drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. 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). **Ask for an exception. Section 5.2**
- Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier. **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

If you disagree with a coverage decision we 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 another 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.

3. **Changing coverage of a drug to a lower cost sharing tier,** Every drug on our Drug List is in one of four cost sharing tiers. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.
   - 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.
   - A drug included under the Non-Part D Supplemental Benefit is not eligible for a tiering exception. (Additional drug coverage is offered by some former employer/union/trusts to cover some prescription drugs not normally covered in a Medicare prescription drug plan.)

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 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. 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 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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.

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

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

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

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

The **independent review organization is an independent organization hired by Medicare.** It 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.**

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? o Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	Did we fail to give you a required notice? Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals.)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: You 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 STRS Ohio**. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period for STRS Ohio** is from November 1, 2023 to November 21, 2023.
- 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, 2025.

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, for the rest of your life, 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 will lose your medical and prescription drug coverage provided by STRS Ohio.

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.**

- STRS Ohio allows members to disenroll at any time throughout the plan year. Please note, you will lose your medical and prescription drug coverage provided by STRS Ohio.
- **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.
  - 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 will lose your medical and prescription drug coverage provided by STRS Ohio.
- **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 disenroll

If you have any questions about disenrolling from SilverScript you can:

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

SECTION 3 How do you disenroll from 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. 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 November 1, 2023 until November 21, 2023 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.

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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 in covered prescription drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422 (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, or if our plan limits the quantity or dosage of the prescription drug you are requesting (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name 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 Limit – The maximum limit of coverage under the Initial Coverage Stage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered 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.

STRS Ohio Annual Maximum Out-of-Pocket (MOOP) – The most you will pay in a year for your share of the cost for covered prescription drugs, for 2024 this amount is $4,000.

Medicare True Out-of-Pocket (TrOOP) – The expenses that count toward a person's Medicare prescription drug plan out-of-pocket threshold (for example, $8,000 in 2024). This includes amounts paid by you or qualified payers on your behalf toward the cost of your covered Medicare Part D prescription drugs. Generally, payments by family and friends and charities count toward TrOOP but not payments by other health plans. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin. In other words, TrOOP defines when you exit the coverage gap (sometimes referred to as the "donut hole") and enter the Catastrophic Coverage Stage of your Medicare Part D prescription drug plan.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term 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 Prescription Drugs – Prescription drugs that can be covered under Part D. We may or may not offer all Part D prescription drugs. Certain categories of prescription drugs have been excluded as covered Part D prescription 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.

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 – A tool within your secure member portal at https://info.caremark.com/oe/strsegwpretiree 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	**KEPRO**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-319-8452, 216-447-9604, **TTY:** 1-855-843-4776, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, **Website:** keproqio.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:** 1-866-868-2289, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, **Website:** livantaqio.com/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:** 1-888-985-2660, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, **Website:** livantaqio.com/en
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**KEPRO**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0751, 813-280-8256, **TTY:** 1-855-843-4776, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, **Website:** keproqio.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:** 1-888-985-8775, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, **Website:** livantaqio.com/en
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	**KEPRO**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-315-0636, 216-447-9604, **TTY:** 1-855-843-4776, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, **Website:** keproqio.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:** 1-888-985-9295, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, **Website:** livantaqio.com/en
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	**KEPRO**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0891, 813-280-8256, **TTY:** 1-855-843-4776, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, **Website:** keproqio.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, **TTY:** 1-855-887-6668, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, **Website:** livantaqio.com/en

	Quality Improvement Organizations (QIO)
Region 10: Alaska, Idaho, Oregon, Washington	**KEPRO**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-305-6759, 813-280-8256, **TTY:** 1-855-843-4776, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, **Website:** keproqio.com

	State Medicaid Office
AK	**Alaska Dept. of Health Division of Public Assistance**, **Address:** 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:** dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx
AL	**Alabama Medicaid Agency**, **Address:** PO Box 5624, Montgomery, AL 36103, **Phone:** 1-800-362-1504, 334-242-5000, **TTY:** 1-800-253-0799, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** medicaid.alabama.gov/
AR	**Arkansas Medicaid**, **Address:** PO Box 1437, Slot S401, Little Rock, AR 72203-1437, **Phone:** 1-800-482-8988, 1-800-482-5431, **TTY:** 501-682-8933, **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:** 801 E. Jefferson Street, Phoenix, AZ 85034, **Phone:** 1-800-654-8713, 602-417-4000, **TTY:** 1-800-842-6520, **Hours:** Monday–Friday 7:00 AM to 9:00 PM, Saturday 8:00 AM to 6:00 PM, **Website:** azahcccs.gov/
CA	**California Department of Health Services Medi-Cal**, **Address:** PO Box 138008, Sacramento, CA 95813-8008, **Phone:** 1-800-541-5555, 916-636-1980, **TTY:** 1-866-784-2595, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhcs.ca.gov
CO	**HealthFirst Colorado**, **Address:** 1570 Grant Street, Denver, CO 80203-1818, **Phone:** 1-800-221-3943, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** healthfirstcolorado.com/
CT	**HUSKY, Connecticut's Health Care for Children & Adults**, **Address:** 55 Farmington Ave., Hartford, CT 06105-3724, **Phone:** 1-877-284-8759, **TTY:** 1-866-492-5276, **Hours:** Monday–Friday 8:30 AM to 6:00 PM, **Website:** portal.ct.gov/HUSKY/Welcome
DC	**The Department of Health Care Finance – DHCF**, **Address:** 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 Health and Social Services/Division of Medicaid and Medical Assistance (DMMA)**, **Address:** DHSS Herman Holloway Campus, Lewis Building, 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

	State Medicaid Office
FL	**Florida Agency for Health Care Administration, Division of Medicaid**, **Address:** 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308, **Phone:** 1-877-711-3662, **TDD:** 1-866-467-4970, **Hours:** Monday–Thursday, 8:00 AM to 8:00 PM, Friday 8:00 AM to 7:00 PM, **Website:** flmedicaidmanagedcare.com/home
GA	**Georgia Medicaid**, **Address:** Division of Family and Children Services, Customer Contact Center, 2 Peachtree Street NW, 19th Floor, Atlanta, GA 30303, **Phone:** 1-877-423-4746, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.georgia.gov/
GU	**Guam Medicaid Assistance Program**, **Address:** Department of Public Health & Social Services, ITC Building, Suite 219, 590 S. Marine Corps Dr., Tamuning, GU 96913-3532, **Phone:** 735-7245/7274 (Central), 635-7429/7488 (Northern), 828-7542/8524 (Southern), **TTY:** 711, **Hours:** 9:00 AM to 4:00 PM, **Website:** dphss.guam.gov
HI	**Hawaii Med-QUEST Division**, **Address:** 1390 Miller Street, Suite 209, Honolulu, HI 96813-2403, **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	**IA Health Link**, **Address:** PO Box 36510, Des Moines, IA 50315, **Phone:** 1-800-338-8366, 515-256-4606, **TTY:** 1-800-735-2942, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.iowa.gov/IAHEALTHLINK
ID	**Idaho Department of Health and Welfare**, **Address:** PO Box 83720, Boise, ID 83720-0036, **Phone:** 1-877-456-1233, **TTY:** 1-888-791-3004, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** idalink.idaho.gov/
IL	**Illinois Department of Healthcare and Family Services**, **Address:** 201 S. Grand Ave. E, Springfield IL 62704, **Phone:** 1-800-843-6154, 1-866-468-7543, **TTY:** 1-800-447-6404, 1-877-204-1012, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** illinois.gov/hfs/Pages/default.aspx
IN	**Indiana Medicaid**, **Address:** 402 W. Washington Street, Room W392, PO Box 7083, Indianapolis, IN 46204, **Phone:** 1-800-403-0864, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** in.gov/medicaid/
KS	**KanCare Medicaid for Kansas**, **Address:** PO Box 3599, Topeka, KS 66601, **Phone:** 1-800-792-4884, **TTY:** 1-800-766-3777, 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kancare.ks.gov/
KY	**Kentucky Cabinet for Health and Family Services, Department for Medicaid Services**, **Address:** 275 E. Main St. 6W-A, Frankfort, KY 40621, **Phone:** 1-800-635-2570, 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 Department of Health**, **Address:** PO Box 629, Baton Rouge, LA 70821-0629, **Phone:** 1-888-342-6207, **TTY:** 1-800-220-5404, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ldh.la.gov/subhome/1
MA	**MassHealth**, **Address:** One Ashburton Place, Boston, MA 02108, **Phone:** 1-800-841-2900, **TTY:** 1-800-497-4648, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mass.gov/orgs/masshealth
MD	**Maryland Medicaid**, **Address:** Herbert R. O'Conor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, **Phone:** 1-877-463-3464, 1-855-642-8572, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** mmcp.health.maryland.gov/Pages/home.aspx

	State Medicaid Office
ME	**Office of MaineCare Services**, **Address:** 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 Program**, **Address:** Capitol View Building, 201 Townsend Street, Lansing, MI 48913, **Phone:** 1-800-642-3195, 517-373-3740, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** michigan.gov/medicaid
MN	**Minnesota Department of Human Services, Medical Assistance (MA)**, **Address:** PO Box 64993, St. Paul, MN 55164-0993, **Phone:** 1-800-657-3739, 651-431-2670, **TTY:** 1-800-627-3529, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
MO	**MO HealthNet**, **Address:** 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, **Phone:** 1-800-392-2161, 573-751-4815, **TTY:** 1-800-735-2466, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mydss.mo.gov/healthcare
MP	**Northern Mariana Islands Medical Assistance for the Needy (MAN) Program**, **Address:** Commonwealth Medicaid Agency, Government Building No. 1252, Capitol Hill Rd., Caller Box 1007 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, 601-659-6050, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.ms.gov/
MT	**Montana Medicaid and HMK Plus**, **Address:** 111 North Sanders Street, Helena, MT 59601-4520, PO Box 4210, Helena, MT 59604-4210, **Phone:** 1-800-362-8312, 1-888-706-1535, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** 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 Department of Human Services, Medical Services Division**, **Address:** 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250, **Phone:** 1-800-755-2604, 701-328-7068, **TTY:** 1-800-366-6888, 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.nd.gov/healthcare/medicaid
NE	**Nebraska Department of Health and Human Services System**, **Address:** 301 Centennial Mall South, Lincoln, NE 68508, **Phone:** 1-855-632-7633, 402-471-3121, **TTY:** 1-800-833-7352, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhs.ne.gov/Pages/General-Medicaid-Information.aspx
NH	**New Hampshire Department of Health and Human Services**, **Address:** Division of Medicaid Services, 129 Pleasant Street, Concord, NH 03301, **Phone:** 1-800-852-3345, ext. 4344, 603-271-4344, **TTY:** 1-800-735-2964, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhhs.nh.gov/programs-services/medicaid

	State Medicaid Office
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:** 1-800-701-0720, **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**, **Address:** NM Human Services Department, PO Box 2348, Santa Fe, NM 87504, **Phone:** 1-800-283-4465, **TTY:** 1-855-227-5485, **Hours:** Monday–Friday 7:00 AM to 5:00 PM, **Website:** hsd.state.nm.us/lookingforassistance/centennial-care-overview/
NV	**Nevada Department of Health and Human Services**, **Address:** Nevada Medicaid, Customer Service, 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	**Medicaid Advantage Plus (MAP)**, **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 5:00 PM, **Website:** health.ny.gov/health_care/medicaid/
OH	**Ohio Department of Medicaid**, **Address:** 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
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	**Pennsylvania Department of Human Services**, **Address:** 625 Forster Street, Harrisburg, PA 17120, **Phone:** 1-800-692-7462, **TTY:** 1-800-451-5886, 711, **Hours:** Monday–Friday 8:30 AM to 4:45 PM, **Website:** dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
PR	**Medicaid Program**, **Address:** Department Of Health, P.O. Box 70184, San Juan, PR 00936-8184, **Phone:** 787-641-4224, **TTY:** 787-625-6955, **Hours:** Monday-Friday 8:00 AM to 6:00 PM, **Website:** medicaid.pr.gov
RI	**Rhode Island Department of Human Services**, **Address:** PO Box 8709, Cranston, RI 02920-8787, **Phone:** 1-855-697-4347, **TTY:** 711, **Hours:** Monday, Tuesday, Thursday, Friday 8:30 AM to 3:00 PM, except holidays, **Website:** eohhs.ri.gov/consumer/health-care
SC	**South Carolina Healthy Connections Medicaid**, **Address:** SCDHHS, PO Box 100101, Columbia, SC 29202, **Phone:** 1-888-549-0820, **TTY:** 1-888-842-3620, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** scdhhs.gov/
SD	**South Dakota Medicaid**, **Address:** 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**, **Address:** 310 Great Circle Road, Nashville, TN 37243, **Phone:** 1-855-259-0701 (Applications), 1-800-342-3145 (General), **TTY:** 1-877-779-3103, **Hours:** Monday–Friday 7:00 AM to 6:00 PM, **Website:** tn.gov/tenncare
TX	**Texas Health and Human Services Commission**, **Address:** 4900 N. Lamar Boulevard, Austin, TX 78751-2316, **Phone:** 1-800-252-8263, **TTY:** 1-800-735-2989, 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/medicaid-chip

	State Medicaid Office
UT	**Utah Department of Health Medicaid**, **Address:** PO Box 143106, Salt Lake City, UT 84114-3106, **Phone:** 1-800-662-9651, 801-538-6155 (Customer Service); 801-526-0950, 1-866-435-7414 (Eligibility),, **TTY:** 711, **Hours:** Monday, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM and Thursday 11:00 AM to 5:00 PM, **Website:** medicaid.utah.gov/
VA	**Cardinal Care Virginia Medicaid**, **Address:** 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, **Hours:** Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, **Website:** dmas.virginia.gov/
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:** Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, **Phone:** 1-800-250-8427, 1-855-899-9600, **TTY:** 711, **Hours:** Monday–Friday 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 Department of Health Services**, **Address:** Division of Medicaid Services, PO Box 309, Madison, WI 53707-0309, **Phone:** 1-800-362-3002, 608-266-1865, **TTY:** 1-800-947-3529, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhs.wisconsin.gov/medicaid/index.htm
WV	**West Virginia Department of Health & Human Resources, Bureau for Medical Services**, **Address:** One Davis Square, Suite 100 East, Charleston, WV 25301, **Phone:** 1-877-716-1212, 304-558-1700, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhr.wv.gov/Pages/default.aspx
WY	**Wyoming Department of Health, Healthcare Financing Division**, **Address:** Customer Service Center, 3001 E. Pershing Blvd., Suite 125, Cheyenne, WY 82001, **Phone:** 1-855-294-2127, 307-777-7531, **TTY:** 1-855-329-5204, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.wyo.gov/

	State Health Insurance Assistance Program (SHIP)
AK	**Alaska State Health Insurance Counseling and Assistance Programs**, **Address:** 1835 Bragaw Street, Suite 350, Anchorage, AK 99508, **Phone:** 1-800-478-6065, 907-269-3680, **TTY:** 1-800-770-8973, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhss.alaska.gov/dsds/Pages/medicare/ship.aspx
AL	**Alabama State Health Insurance Assistance Program**, **Address:** 201 Monroe Street, RSA Tower, Suite 350, Montgomery, AL 36130-1851, **Phone:** 1-800-243-5463, 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 Senior Health Insurance Information Program (AR SHIIP)**, **Address:** 1 Commerce Way, Little Rock, AR 72202, **Phone:** 1-800-224-6330, 501-372-2782, **TTY:** 501-683-4468, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** shiipar.com

	State Health Insurance Assistance Program (SHIP)
AZ	**Arizona State Health Insurance Assistance Program**, **Address:** 1789 W. Jefferson Street, Mail Drop 6288, Phoenix, AZ 85007, **Phone:** 1-800-432-4040, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** des.az.gov/services/older-adults/medicare- assistance
CA	**California Health Insurance Counseling and Advocacy Program (HICAP)**, **Address:** 2880 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, **Phone:** 1-800-434-0222, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.ca.gov/hicap/
CO	**Colorado Senior Health Insurance Assistance Program (SHIP)**, **Address:** 1560 Broadway, Suite 850, Denver, CO 80202, **Phone:** 1-888-696-7213, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare
CT	**CHOICES**, **Address:** 55 Farmington Ave., 12th Floor, Hartford, CT 06105, **Phone:** 1-800-994-9422, **TTY:** 860-247-0775, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** portal.ct.gov/ADS-CHOICES
DC	**Health Insurance Counseling Project (HICP)**, **Address:** 500 K Street NE, Washington, DC 20002, **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:** 1351 W. 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:** delawareinsurance.gov/DMAB/
FL	**Serving Health Insurance Needs of Elders (SHINE)**, **Address:** 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, **Phone:** 1-800-963-5337, **TTY:** 1-800-955-8770, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridashine.org/
GA	**Georgia SHIP**, **Address:** 2 Peachtree Street NW, 33rd Floor, 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 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:** Executive Office on Aging, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, **Phone:** 1-888-875-9229, 808-586-7299, **TTY:** 1-866-810-4379, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** hawaiiship.org/
IA	**Iowa Senior Health Insurance Information Program (SHIIP)**, **Address:** 1963 Bell Ave., Suite 100, Des Moines, IA 50315, **Phone:** 1-800-351-4664, **TTY:** 1-800-735-2942, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** shiip.iowa.gov/
ID	**Idaho Senior Health Insurance Benefits Advisors (SHIBA)**, **Address:** 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 (SHIP)**, **Address:** 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:** 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787, **Phone:** 1-800-452-4800, **TTY:** 1-866-846-0139,

	State Health Insurance Assistance Program (SHIP)
	Hours: Monday–Friday 8:00 AM to 4:30 PM, **Website:** in.gov/ship/
KS	**Senior Health Insurance Counseling for Kansas (SHICK)**, **Address:** New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, **Phone:** 1-800-860-5260, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick
KY	**Kentucky State Health Insurance Assistance Program**, **Address:** 275 E. Main Street, Suite 3E-E, Frankfort, KY 40621, **Phone:** 1-877-293-7447 (Option 2), 502-564-6930, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dail/Pages/ship.aspx
LA	**Louisiana Senior Health Insurance Information Program (SHIIP)**, **Address:** 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)**, **Address:** 1 Ashburton Place, 5th Floor, Boston, MA 02108, **Phone:** 1-800-243-4636, **TTY/ASCII:** TTY/ASCII: 1-800-439-2370, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mass.gov/health-insurance-counseling
MD	**Maryland State Health Insurance Assistance Program**, **Address:** 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:** 109 Capitol Street, 11 State House Station, Augusta, ME 04333, **Phone:** 1-800-262-2232, **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/Medicaid Assistance Program (MMAP, INC.)**, **Address:** 6105 W. St. Joseph, Suite 204, Lansing, MI 48917, **Phone:** 1-800-803-7174, **TTY:** 1-888-263-5897, **Hours:** Monday–Friday 8:00 AM to 7:00 PM, **Website:** mmapinc.org/
MN	**Minnesota State Health Insurance Assistance Program (SHIP)**, **Address:** 540 Cedar Street, PO Box 64976, St. Paul, MN 55164, **Phone:** 1-800-333-2433, **TTY:** 1-800-627-3529, **Hours:** Monday–Friday 8:00AM to 4:30 PM, **Website:** mn.gov/senior-linkage-line/
MO	**Missouri SHIP**, **Address:** 601 W. Nifong Blvd. Suite 3A, Columbia, MO 65203, **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:** 200 South Lamar St., Jackson, MS 39201, **Phone:** 1-800-948-3090, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/
MT	**Montana State Health Insurance Assistance Program (SHIP)**, **Address:** PO Box 4210, Helena, MT 59604, **Phone:** 1-800-551-3191, **TTY:** 1-800-833-8503, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/sltc/aging/ship
NC	**Seniors' Health Insurance Information Program (SHIIP)**, **Address:** Albemarle Building, 325 N. Salisbury Street, Raleigh, NC 27603, **Phone:** 1-855-408-1212, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip

	State Health Insurance Assistance Program (SHIP)
ND	**State Health Insurance Counseling Program (SHIC)**, **Address:** 600 E. Boulevard Ave., Bismarck, ND 58505-0320, **Phone:** 1-888-575-6611, **TTY:** 1-800-366-6888, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** insurance.nd.gov/shic-medicare
NE	**Nebraska SHIP**, **Address:** 2717 S. 8th Street, Suite 4, Lincoln, NE 68502, **Phone:** 1-800-234-7119, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** doi.nebraska.gov/consumer/senior-health
NH	**New Hampshire State Health Insurance Assistance Program (SHIP)**, **Address:** 129 Pleasant Street, Concord, NH 03301, **Phone:** 1-866-634-9412, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** servicelink.nh.gov/medicare/index.htm
NJ	**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:** state.nj.us/humanservices/doas/services/ship
NM	**New Mexico State Health Insurance Assistance Program (SHIP)**, **Address:** 2550 Cerrillos Road, Santa Fe, NM 87505, **Phone:** 1-800-432-2080, 505-476-4846, **TTY:** 505-476-4937, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** aging.nm.gov
NV	**Nevada State Health Insurance Assistance Program (SHIP)**, **Address:** 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:** 50 W. Town Street, Third Floor, Suite 300, Columbus, OH 43215, **Phone:** 1-800-686-1578, 614-644-2658, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** insurance.ohio.gov
OK	**Oklahoma Senior Health Insurance Counseling Program (SHIP)**, **Address:** 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:** 350 Winter Street NE, Salem, OR 97309-0405, **Phone:** 1-800-722-4134, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** shiba.oregon.gov/
PA	**Pennsylvania Medicare Education and Decision Insight (PA MEDI)**, **Address:** 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, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx

	State Health Insurance Assistance Program (SHIP)
RI	**State Health Insurance Assistance Program (SHIP)**, **Address:** 25 Howard Ave., Building 57, Cranston, RI 02920, **Phone:** 1-888-884-8721, **TTY:** 401-462-0740, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oha.ri.gov/Medicare
SC	**State Health Insurance Assistance Program (SHIP)**, **Address:** 1301 Gervais Street, Suite 350, Columbia, SC 29201, **Phone:** 1-800-868-9095, **TTY:** 1-888-842-3620, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** getcaresc.com/guide/insurance-counseling-medicaremedicaid
SD	**Senior Health Information and Insurance Education (SHIINE)**, **Address:** 700 Governors Drive, Pierre, SD 57501-2291, **Phone:** 1-800-536-8197 (Eastern SD), 1-877-331-4834 (Central SD), 1-877-286-9072 (Western SD), **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 4:30 PM, **Website:** shiine.net/
TN	**Tennessee SHIP (State Health Insurance Assistance Program)**, **Address:** Andrew Jackson Bldg., 9th Floor, 502 Deaderick Street, Nashville, TN 37243, **Phone:** 1-877-801-0044, **TTY:** 1-800-848-0299, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tnmedicarehelp.com/
TX	**Texas Health Information, Counseling and Advocacy Program (HICAP)**, **Address:** 701 W. 51st Street, MC: W275, Austin, TX 78751, **Phone:** 1-800-252-9240, **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:** 195 N. 1950 West, Salt Lake City, UT 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:** 1610 Forest Ave., Suite 100, Henrico, VA 23229, **Phone:** 1-800-552-3402, **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:** Commissioner of Banking & Insurance, 4007 Estate Diamond Ruby - 1st Floor, Christiansted, VI 00820, **Phone:** 340-772-7368, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ltg.gov.vi/departments/vi-ship-medicare/
VT	**Vermont State Health Insurance Assistance Program (SHIP)**, **Address:** 476 Main Street, Suite 3, Winooski, VT 05404, **Phone:** 1-800-642-5119, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** vermont4a.org/medicare-information
WA	**Washington Statewide Health Insurance Benefits Advisors (SHIBA)**, **Address:** Office of the Insurance Commissioner, 5000 Capitol Blvd., Tumwater, WA 98504-0256, **Phone:** 1-800-562-6900, **TTY:** 360-586-0241, **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:** 1 W. Wilson Street, Madison, WI 53703, **Phone:** 1-800-242-1060, **TTY:** 1-800-947-3529, 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhs.wisconsin.gov/benefit- specialists/medicare-counseling.htm
WV	**West Virginia State Health Insurance Assistance Program (WV SHIP)**, **Address:** 1900 Kanawha Blvd. East, (3rd Floor Town Center Mall) Charleston, WV 25305-0160, **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 to 4:00 PM, **Website:** wyomingseniors.com/

	State Pharmaceutical Assistance Program (SPAP)
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, 1-800-464-4357, **TTY:** 711, **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/medicaid/members/member-programs/hoosierrx/
MA	**Prescription Advantage**, **Address:** PO Box 15153, Worcester, MA 01615-0153, **Phone:** 1-800-243-4636, **TTY:** 1-877-610-0241, **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, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** marylandspdap.com/
ME	**Maine Low Cost Drugs for the Elderly or Disabled Program**, **Address:** Office of Family Independence, State of Maine - DHHS, 114 Corn Shop Lane, Farmington, ME 04938, **Phone:** 1-855-797-4357, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** apps1.web.maine.gov/benefits/account/login.html
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, **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:** dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
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:** state.nj.us/humanservices/doas/services/paad/
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:** state.nj.us/humanservices/doas/services/seniorgold/
NM	**New Mexico Medical Insurance Pool (NMMIP)**, **Address:** 1223 St. Francis Drive, Suite B, Santa Fe, NM 87505, **Phone:** 1-844-728-7896, 620-793-1121, **TTY:** 1-844-728-7987, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nmmip.org

	State Pharmaceutical Assistance Program (SPAP)
NV	**Nevada Disability Rx Program**, **Address:** ADSD, Attn: SRx/DRx, 3208 Goni Road, Building I, Suite 181, Carson City, NV 89706, **Phone:** 1-866-303-6323, Option 2, 775-687-4210, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** adsd.nv.gov/Programs/Physical/DisabilityRx/DisabilityRx/
NV	**Nevada Senior Rx Program**, **Address:** ADSD, Attn: SRx/DRx, 3208 Goni Road, Building I, Suite 181, Carson City, NV 89706, **Phone:** 1-866-303-6323, Option 2, 775-687-4210, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/
NY	**Elderly Pharmaceutical Insurance Coverage (EPIC) Program**, **Address:** EPIC, PO Box 15018, Albany, NY 12212-5108, **Phone:** 1-800-332-3742, **TTY:** 1-800-290-9138, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.ny.gov/health_care/epic/
PA	**PACE/PACENET Prescription Assistance Program**, **Address:** Pennsylvania Department of Aging, PO Box 8806, Harrisburg, PA 17105-8806, **Phone:** 1-800-225-7223, 717-787-7313, **TTY:** 1-800-222-9004, **Hours:** Monday–Friday 8:00 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 2, **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, 717-787-7313, **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, Option 2, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/kidney-health- care
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 4:00 PM, **Website:** dvha.vermont.gov/members/prescription-assistance
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 4:30 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:** 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
AZ	**Arizona AIDS Drug Assistance Program (ADAP)**, **Address:** Arizona Department of Health Services, 150 N. 18th Ave., Suite 280, Phoenix, AZ 85007, **Phone:** 1-800-334-1540, 602-364-3610, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home
CA	**California AIDS Drug Assistance Program (ADAP)**, **Address:** PO Box 997377, MS 0500, Sacramento, CA 95899-7377, **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:** 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:** State of CT 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 4:00 PM, **Website:** ctdph.magellanrx.com/
DC	**DC AIDS Drug Assistance Program (ADAP)**, **Address:** 899 North Capitol Street NE, Washington, DC 20002, **Phone:** 202-671-4815, **TTY:** 711, **Hours:** Monday–Friday 8:15 AM to 4:45 PM, except district holidays, **Website:** dchealth.dc.gov/DC-ADAP
DE	**Delaware AIDS Drug Assistance Program (ADAP)**, **Address:** 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:** HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, **Phone:** 1-800-352-2437, 844-381-2327, **TTY:** 1-888-503-7118, **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:** 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

	State AIDS Drug Assistance Programs (ADAP)
HI	**Hawaii HIV Drug Assistance Program (HDAP)**, **Address:** 3627 Kilauea Ave., Suite 306, Honolulu, HI 96816, **Phone:** 808-733-9360, **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:** Lucas State Office Building, 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:** idph.iowa.gov/hivstdhep/hiv/support
ID	**Idaho AIDS Drug Assistance Program (ADAP)**, **Address:** 450 W. State Street, PO Box 83720, Boise, ID 83720-0036, **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:** 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:** 2 N. Meridian Street, Suite C, Indianapolis, IN 46204, **Phone:** 1-866-588-4948, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** in.gov/health/hiv-std-viral-hepatitis/hiv-services/
KS	**The Ryan White Part B Program**, **Address:** Curtis State Office Building, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, **Phone:** 785-296-6174, Option 5, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kdhe.ks.gov/355/The-Ryan-White-Part-B-Program
KY	**Kentucky AIDS Drug Assistance Program (KADAP)**, **Address:** 275 E. 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 Health Access Program (LA HAP)**, **Address:** 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/
MA	**Massachusetts HIV/AIDS Drug Assistance Program (HDAP)**, **Address:** AccessHealth MA, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129, **Phone:** 1-800-228-2714, 617-502-1700, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** accesshealthma.org/drug-assistance/hdap/
MD	**Maryland AIDS Drug Assistance Program (MADAP)**, **Address:** 1223 W. Pratt Street, Baltimore, MD 21223, **Phone:** 1-800-205-6308, 410-767-6535, **TTY:** 1-800-735-2258, **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:** Maine Ryan White Program, 40 State House Station, Augusta, ME 04330, **Phone:** 207-287-3747, **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 HIV/AIDS Drug Assistance Program (MIDAP)**, **Address:** Michigan Drug Assistance Program, HIV Care Section, Division of HIV/STI Programs, Client, and Partner Services, Bureau of HIV and STI Programs, Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909, **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 (Program HH)**, **Address:** Minnesota Department of Human Services, Program HH, PO Box 64972, St. Paul, MN 55164-0972, **Phone:** 1-800-657-3761, 651-431-2414, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM,

	State AIDS Drug Assistance Programs (ADAP)
	Website: rainbowhealth.org/living-with-hiv/assistance/health-insurance/program-hh/
MO	**Missouri HIV/AIDS Case Management Program**, **Address:** Bureau of HIV, STD, and Hepatitis, Missouri 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
MS	**Mississippi AIDS Drug Assistance Program (ADAP)**, **Address:** Office of STD/HIV Care and Treatment Division, 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:** 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:** NC Department of Health and Human Services Division of Public Health, Purchase of Medical Care 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:** North Dakota Department of Health, Division of Disease Control, 2635 E. Main Avenue, PO Box 5520, Bismarck, ND 58505, **Phone:** 1-800-472-2180, 701-328-2378, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ndhealth.gov/hiv/
NE	**Nebraska Ryan White AIDS Drug Assistance Program (ADAP)**, **Address:** Nebraska Department of Health & 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 Ryan White CARE Program**, **Address:** 29 Hazen Drive, Concord, NH 03301, **Phone:** 1-800-852-3345 ext. 4502, 603-271-4502, **TTY:** 711, **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
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:** Infectious Disease Bureau, Public Health Division, 1190 S. St. Francis Drive, Room S-1204, Santa Fe, NM 87505, **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)/NV Medication Assistance Program**, **Address:** 2290 S. Jones Blvd., Suite 110, Las Vegas, Nevada 89146, **Phone:** 702-486-0768, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** endhivnevada.org
NY	**New York AIDS Drug Assistance Program (ADAP)**, **Address:** HIV 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, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.ny.gov/diseases/aids/general/resources/adap/

	State AIDS Drug Assistance Programs (ADAP)
OH	**Ohio HIV Drug Assistance Program (OHDAP)**, **Address:** Ohio 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:** Oklahoma State Department of Health, Sexual Health and Harm Reduction Services, 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 CAREAssist**, **Address:** 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 – HIV/AIDS**, **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
RI	**Rhode Island AIDS Drug Assistance Program (ADAP)**, **Address:** Executive Office of Health & Human Services, Virks Building, 3 West Rd., Suite 227, 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:** SC Drug Assistance Program/Insurance Assistance Program, 3rd Floor, Mills/Jarrett Box 101106, Columbia, SC 29211, **Phone:** 1-800-856-9954, **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/diseases/infectious/ryanwhite/
TN	**Tennessee AIDS Drug Assistance Program (ADAP)**, **Address:** TN Department of Health, HIV/STD Program, Ryan White Part B Services, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243, **Phone:** 1-800-525-2437, 615-741-7500, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
TX	**Texas HIV Medication Program (THMP)**, **Address:** 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 Ryan White Part B ADAP AIDS Drug Assistance Program**, **Address:** Utah Department of Health, Bureau of Epidemiology, 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:** ptc.health.utah.gov/treatment/ryan-white/
VA	**Virginia Medication Assistance Program (VA MAP)**, **Address:** Department of Health, 109 Governor Street, Richmond, VA 23219, **Phone:** 1-855-362-0658, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** vdh.virginia.gov/disease-prevention/vamap/

	State AIDS Drug Assistance Programs (ADAP)
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 ext. 4005, **TTY:** 711, **Hours:** Monday–Friday 7:45 AM to 3:30 PM, **Website:** healthvermont.gov/immunizations-infectious-disease/hiv/care
WA	**Washington Early Intervention Program (EIP)**, **Address:** Client Services, PO Box 47841, Olympia, WA 98504, **Phone:** 1-877-376-9316, 360-236-3426, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, except state holidays, **Website:** doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP
WI	**Wisconsin AIDS/HIV Drug Assistance Program (ADAP)**, **Address:** Division of Public Health, Attn: ADAP, PO Box 2659, Madison, WI 53701, **Phone:** 1-800-991-5532, 608-261-6952, **TTY:** 711, **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:** Jay Adams, HIV Care Coordinator, 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:** Wyoming Department of Health, 122 W. 25th Street, 3rd Floor West, Cheyenne, WY 82002, **Phone:** 307-777-5856, **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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