aetna®

Aetna Medicare Rx® (PDP)
Offered by Aetna Life Insurance Company

Annual Notice of Changes for 2019

September 2018

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 for information about benefit and cost changes for our plan.

☐ Check the changes to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section *1.3* for information about changes to our drug coverage.
- Your drug prices may have risen or you may have had alternate medications suggested to you. For information about drug prices visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/index.html. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. These are general or total prices and increases probably don't match changes in what you will pay.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles, if applicable?

2. **COMPARE:** Learn about other plan choices - Your coverage is offered through your former employer/union/trust.

   It is important that you carefully consider your decision before changing your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans.

   ☐ Contact your benefits administrator to see if there are other options available.

   ☐ Check coverage and costs of individual Medicare health plans in your area.

   - Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
   - Review the list in the back of your Medicare & You handbook.
   - Look in Section 3 to learn more about your choices.

3. **CHOOSE:** Decide whether you want to change your plan

   ☐ If you want to **keep** the same Aetna Medicare plan, your plan benefits administrator will give you instructions if there is any action you need to take to remain enrolled.

   ☐ You can change your coverage during your former employer/union/trust's open enrollment period. Your plan benefits administrator will tell you what other plan choices might be available to you under your group retiree coverage.

   ☐ You can switch to an individual Medicare health plan or to Original Medicare; however, this would mean dropping your group retiree coverage. As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your former employer/union/trust's plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time. Look in Section 3.2 to learn more about your choices.

4. **ENROLL:** To change plans, call the benefits administrator of your former employer or retiree group for information.

Additional Resources

- This document is available for free in Spanish
- Please contact Customer Service at the telephone number on the back of your Aetna member ID card or call our general customer service center at 1-844-233-1939 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.
- This document may be made available in other formats such as Braille, large print or other alternate formats. Please contact Customer Service for more information.

About Aetna Medicare Rx (PDP)

- Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Aetna Medicare. When it says “plan” or “our plan,” it means Aetna Medicare Rx (PDP).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for our plan in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* and *Prescription Drug Schedule of Cost Sharing* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid)	**$179.26**	**$181.09**
Part D prescription drug coverage (See Section 1.3 for details.)	Deductible: **Not Applicable**	Deductible: **Not Applicable**
For a one-month (30-day) supply of a drug that is filled at a network pharmacy that provides standard cost-sharing. **The list of covered drugs associated with your plan will change for 2019. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.**	Copays during the Initial Coverage Stage: **Tier 1 – Preferred generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 2 – Generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 3 – Preferred brand drugs:** You pay 25%, but not more than $100, for your drug **Tier 4 – Non-preferred drugs:** You pay 50%, but not more than $150, for your drug **Tier 5 – Specialty drugs:** You pay 25% for your drug	Copays during the Initial Coverage Stage: **Tier 1 – Preferred generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 2 – Generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 3 – Preferred brand drugs:** You pay 25%, but not more than $100, for your drug **Tier 4 – Non-preferred drugs:** You pay 50%, but not more than $150, for your drug **Tier 5 – Specialty drugs:** You pay 25% for your drug

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium (if applicable)

Cost	2018 (this year)	2019 (next year)
Monthly premium **(You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)**	**$179.26**	**$181.09**

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

If Aetna bills you directly for your total plan premium, we will mail either a monthly invoice or an annual coupon book detailing your premium amount.

You must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**. Page 1 of your *Prescription Drug Schedule of Cost Sharing* lists the name of your 2019 pharmacy network. Please refer to this network name when looking for 2019 network pharmacies. The *Prescription Drug Schedule of Cost Sharing* is enclosed in this packet.

An updated *Pharmacy Directory* is located on our website at http://www.aetnamedicare.com/findpharmacy. You may also call Customer Service for updated pharmacy information or to ask us to mail you a *Pharmacy Directory*.

Section 1.3 Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 7 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover.

In some situations, we will cover a, temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days of medication rather than the amount provided in 2018 (98 days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 3, Section 5.2 of the *Evidence of Coverage*.) After you get this temporary supply, you should talk with your doctor to decide what to do when your temporary supply runs out. Here are your options:

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. Your doctor can help to find a covered drug that might work for you.
- You and your doctor can ask the plan to make an exception for you and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* included with this *Annual Notice of Changes*. Look for Chapter 7, Section 5 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You can ask for an exception for Part D drugs that are not on the formulary. You can also ask for an exception for Part D drugs that are on our formulary but with a restriction, such as prior authorization, step therapy, or quantity limit.

If you are currently taking a Part D drug that will no longer be on the formulary as of January 1, 2019, or a Part D drug that will have new restrictions on it beginning on January 1st, you can ask for an exception before that date to make sure we will continue covering that drug. Here is what will happen if you do not request an exception for those drugs before January 1, 2019:

- If the Part D drug you are taking will no longer be on the formulary or will have a restriction beginning January 1, 2019, we will cover up to a 30-day temporary supply (unless your prescription is written for fewer days) of the Part D drug for the first 90 days of the new plan year starting on January 1st.
- If you live in a long-term care facility and the Part D drug you are taking will no longer be on the formulary or will have a restriction beginning January 1, 2019, we will allow you to refill your prescription until we have provided you with at least a 31-day supply, consistent with the dispensing increment (unless your prescription is written for fewer days). We will cover more than one refill of this drug for the first 90 days of the new plan year starting on January 1st.
- If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with temporary coverage (up to a 30-day supply) for the applicable drug(s).

Regardless of the reason you received a temporary supply, you will need to utilize our exception process if you need to continue on the current drug.

Important Note: Please take advantage of filing your exception requests before January 1st. It will make for a very easy transition into the next calendar year. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this Annual Notice of Changes. Look for Chapter 7 of the *Evidence of Coverage* (What to do if you have a problem or complaint).

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. -Because you receive "Extra Help" and haven't received this insert by September 30, 2018, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 4, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 4, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

Your cost-sharing in the initial coverage stage for certain tier drugs may be changing from copayment to coinsurance or coinsurance to copayment. Please see the following chart for the changes from 2018 to 2019.

To learn how copayments and coinsurance work, look at Chapter 4, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage.*

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in the 2019 *Prescription Drug Schedule of Cost Sharing* included in this packet. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy **Standard Cost Sharing Tier 1 – Preferred generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 2 – Generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 3 – Preferred brand drugs:** You pay 25%, but not more than $100, for your drug **Tier 4 – Non-preferred drugs:** You pay 50%, but not more than $150, for your drug **Tier 5 – Specialty drugs:** You pay 25% for your drug Once your total drug costs have reached $5,000, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy **Standard Cost Sharing Tier 1 – Preferred generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 2 – Generic drugs:** You pay 25%, but not more than $30, for your drug **Tier 3 – Preferred brand drugs:** You pay 25%, but not more than $100, for your drug **Tier 4 – Non-preferred drugs:** You pay 50%, but not more than $150, for your drug **Tier 5 – Specialty drugs:** You pay 25% for your drug Once your total drug costs have reached $5,100, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

For information about your costs in these stages, look in the 2019 *Prescription Drug Schedule of Cost Sharing* included in this packet.

SECTION 2 Administrative Changes

Process	2018 (this year)	2019 (next year)
Part B Deductible		CMS Part B Deductible letter will be mailed upon receipt of 2019 deductible amounts.
Appeals for Part D Prescription Drugs – Phone number and hours of operation	1-877-235-3755 8 a.m. to 8 p.m. local time, 7 days a week	1-844-233-1939 24 hours a day, 7 days a week
Fax number for expedited/fast complaint (grievance process)	1-866-604-7092	1-724-741-4956

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If You Want to Stay in Aetna Medicare Rx (PDP) Plan

Your benefits administrator will tell you if you need to do anything to stay enrolled in your Aetna Medicare Rx (PDP) plan.

Section 3.2 If You Want to Change Plans

We hope to keep you as a member. However, if you want to change your plan, here are your options:

Step 1: Learn about and compare your choices

- You can join a different Medicare prescription drug plan. Your plan benefits administrator will let you know what options are available to you under your group retiree coverage.
- -- *OR*-- You can switch to an individual Medicare prescription drug plan.
- -- *OR*-- You can change to a Medicare health plan. Some Medicare health plans also include Part D prescription drug coverage,

- -- *OR*-- You can keep your current Medicare health coverage and drop your Medicare prescription drug coverage.

It is important that you carefully consider your decision before dropping your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans. Call the benefits administrator of your former employer or retiree group for information.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Aetna offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare prescription drug plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
- To **change to a Medicare health plan**, enroll in the new plan. Depending on which type of plan you choose, you may automatically be disenrolled from our plan.
  - You will automatically be disenrolled from our plan if you enroll in any Medicare health plan that includes Part D prescription drug coverage. You will also automatically be disenrolled if you join a Medicare HMO or Medicare PPO, even if that plan does not include prescription drug coverage.
  - If you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep our plan for your drug coverage. Enrolling in one of these plan types will not automatically disenroll you from our plan. If you are enrolling in this plan type and want to leave our plan, you must ask to be disenrolled from Aetna Medicare Rx (PDP). To ask to be disenrolled, you must send us a written request 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).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).

- – *or* – 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 Deadline for Changing Plans

You may be able to change to a different plan during your former employer/union/trust's open enrollment period. Your plan may allow you to make changes at other times as well. Your plan's benefits administrator will let you know what other plan options may be available to you.

Are there other times of the year to make a change?

As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your former employer/union/trust's plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time during the year.

It is important that you carefully consider your decision before dropping your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans. Call the benefits administrator of your former employer or retiree group for information.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

SHIPs are independent (not connected with any insurance company or health plan). They are state programs that get money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call your SHIP at the phone number in Addendum A at the back of the *Evidence of Coverage*.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the state ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP (the name and phone numbers for this organization are in Addendum A at the back of the *Evidence of Coverage*).

SECTION 7 Questions?

Section 7.1 Getting Help from Aetna Medicare RX (PDP)

Questions? We're here to help. Please call Customer Service at the telephone number on the back of your Aetna member ID card or call our general customer service center at 1-844-233-1939. (TTY only, call 711.) We are available for phone calls 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details about your plan, look in the 2019 *Evidence of Coverage* and the Prescription Drug Schedule of Cost Sharing. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope. The Prescription Drug Schedule of Cost Sharing lists the out-of-pocket cost share for your plan; a copy is included in this envelope.

Visit our Website

You can also visit our website athttp://AetnaRetireePlans.com. As a reminder, our website has the most up-to-date information about our pharmacy network (*Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

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.

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare prescription drug plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on "Review and Compare Your Coverage Options.")

Read *Medicare & You 2019*

You can read *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

AETNA LIFE INSURANCE COMPANY

Former Employer/Union/Trust Name: Kansas State Employee Health Plan
Group Agreement Effective Date: January 1, 2019
Group Number: AE466595, AE466596, AE466597, AE466598

This Prescription Drug Schedule of Cost Sharing is part of the *Evidence of Coverage* (EOC) for our plan. When the EOC refers to the attachment for details of Medicare Part D prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart. (See the EOC chapters titled "Using the plan's coverage for your Part D prescription drugs" and "What you pay for your Part D prescription drugs.")

Annual Deductible Amount per Member	**$0**
Formulary Type:	**GRP B2**
Initial Coverage Limit:	**$3,820**
True Out-of-Pocket Amount:	**$5,100**
Retail Pharmacy Network: S2 The name of your pharmacy network is listed above. To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (http://www.aetnamedicare.com/findpharmacy), or call Customer Service (phone numbers are printed on your member ID card).	

Every drug on the plan's Drug List is in one of the cost-sharing tiers described below:

- Tier One – Preferred generic drugs: Includes low-cost generic drugs
- Tier Two – Generic drugs: Includes generic drugs
- Tier Three – Preferred brand drugs: Includes preferred brand drugs and some high-cost generic drugs
- Tier Four – Non-preferred drugs: Includes non-preferred brand drugs and some higher-cost generic drugs
- Tier Five – Specialty drugs: Includes high-cost/unique brand and generic drugs

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

Initial Coverage Stage: Amount you pay, up to $3,820 in total covered prescription drug expenses.

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs – Includes low-cost generic drugs	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $45, for your drug	You pay 25%, but not more than $45, for your drug
Tier 2 Generic drugs – Includes generic drugs	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $45, for your drug	You pay 25%, but not more than $45, for your drug
Tier 3 Preferred brand drugs – Includes preferred brand drugs and some high-cost generic drugs	You pay 25%, but not more than $100, for your drug	You pay 25%, but not more than $100, for your drug	You pay 25%, but not more than $100, for your drug	You pay 25%, but not more than $150, for your drug	You pay 25%, but not more than $150, for your drug

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 4 Non-preferred drugs – Includes non-preferred brand drugs and some higher-cost generic drugs	You pay 50%, but not more than $150, for your drug	You pay 50%, but not more than $150, for your drug	You pay 50%, but not more than $150, for your drug	You pay 50%, but not more than $225, for your drug	You pay 50%, but not more than $225, for your drug
Tier 5 Specialty drugs – Includes high-cost/ unique brand and generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Coverage Gap Stage: Amount you pay after you reach $3,820 in total covered prescription drug expenses and until you reach $5,100 in out-of-pocket covered prescription drug costs.

Your Plan's gap coverage is listed in the chart below.

Supplemental Gap Coverage	**One-Month Supply**			**Extended Supply**	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs – Includes low-cost generic drugs	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $45, for your drug	You pay 25%, but not more than $45, for your drug
Tier 2 Generic drugs – Includes generic drugs	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $30, for your drug	You pay 25%, but not more than $45, for your drug	You pay 25%, but not more than $45, for your drug
Tier 3 Preferred brand drugs – Includes preferred brand drugs and some high-cost generic drugs	You pay 25%, but not more than $100, for your drug	You pay 25%, but not more than $100, for your drug	You pay 25%, but not more than $100, for your drug	You pay 25%, but not more than $150, for your drug	You pay 25%, but not more than $150, for your drug

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 4 Non-preferred drugs – Includes non-preferred brand drugs and some higher-cost generic drugs	You pay 25%, but not more than $150, for your drug	You pay 25%, but not more than $150, for your drug	You pay 25%, but not more than $150, for your drug	You pay 25%, but not more than $225, for your drug	You pay 25%, but not more than $225, for your drug
Tier 5 Specialty drugs – Includes high-cost/ unique brand and generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

The Kansas State Employee Health Plan provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching $5,100 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount: –*either* – coinsurance of 5% of the cost of the drug –*or* – $3.40 copayment for a generic drug or a drug that is treated like a generic. Or a $8.50 copayment for all other drugs. Our plan pays the rest of the cost.

Step Therapy

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

This Plan Uses the GRP B2 Formulary:

Your plan uses the GRP B2 formulary, which means that only drugs on Aetna's drug list will be covered under your plan as long as the drug is medically necessary and the plan rules are followed. Tiers labeled as brand, preferred brand, and non-preferred drug will also include some high-cost generic drugs. Non-preferred copayment levels may apply to some drugs on the drug list. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2019 Group Formulary (List of Covered Drugs)* for more information.

aetna®

January 1 – December 31, 2019

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Aetna Medicare Rx® (PDP).

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2019. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Aetna Medicare Rx (PDP), is offered by Aetna Life Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Aetna Life Insurance Company. When it says "plan" or "our plan," it means Aetna Medicare Rx (PDP).)

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. This information is available for free in other languages.

This document is available for free in Spanish.

Please contact our Customer Service at the telephone number printed on your member ID card for additional information. You may also call our general Customer Service center at 1-844-233-1939. (TTY users should call 711). Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

This document may be made available in other formats such as Braille, large print or other alternate formats.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2020. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OMB Approval 0938-1051 (Pending OMB Approval)

2019 Evidence of Coverage

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

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SECTION 1 Introduction

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

Your coverage is provided through a contract with the Kansas State Employee Health Plan. You are covered by Medicare, and you get your Medicare prescription drug coverage through our plan, Aetna Medicare Rx (PDP).

There are different types of Medicare plans. Aetna Medicare Rx (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

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

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

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

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

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on your member ID card).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in our plan between January 1, 2019 and December 31, 2019.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2019. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2019.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. Kansas State Employee Health Plan can continue to offer you Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have Medicare Part A or Medicare Part B (or you have both Medicare Part A and Medicare Part B) (section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (section 2.3 below describes our service area)

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

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

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

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

Section 2.3 The plan service area

Although Medicare is a Federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Your service area is the state where you live when you enroll in our plan. If you move out of the service area, you will have a Special Enrollment Period that will allow you to switch to a different plan. Please contact the Kansas State Employee Health Plan administrator to see what other plan options are available to you in your new location. If you move, please contact Customer Service at the telephone number on your member ID card.

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

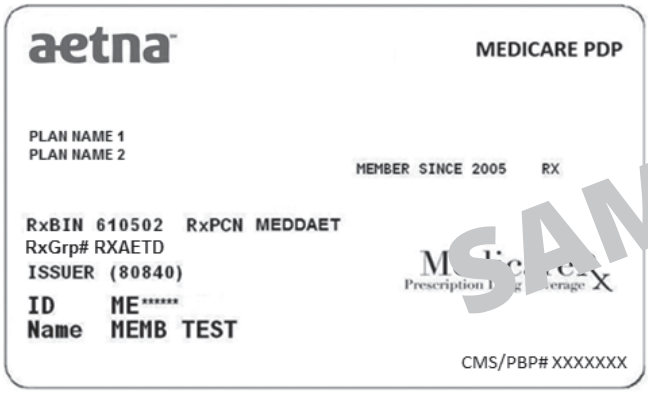
Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?

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

While you are a member of our plan, you must use your membership card for our plan for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Please continue to use your current Aetna Medicare ID card. A new card will be issued if there are changes made to the content printed on your card. Or, if you request one to be sent. Here's a sample membership card to show you what yours will look like:



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on your member ID card.)

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

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

What are "network pharmacies"?

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

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at https://www.aetnamedicare.com/findpharmacy. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2019 *Pharmacy Directory* to see which pharmacies are in our network**.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are printed on your member ID card). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at https://www.aetnamedicare.com/findpharmacy.

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

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

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

We have included a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (http://www. AetnaRetireePlans.com) or call Customer Service (phone numbers are printed on your member ID card).

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

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

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

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on your member ID card).

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium (if applicable)?

Your coverage is provided through a contract with the Kansas State Employee Health Plan.

As a member of our plan, you pay a monthly plan premium. For 2018, the monthly plan premium was $179.26. For 2019, the monthly plan premium is $181.09.

If you have an Aetna plan premium and are billed directly by Aetna Medicare for the full amount of the premium, we will mail you a monthly invoice or an annual coupon book detailing your premium amount. If you have an Aetna plan premium and you are not billed directly by Aetna Medicare for this premium, please refer to your plan benefits administrator for any premium payment information.

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).

In some situations, your plan premium could be less

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

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

In some situations, your plan premium could be more

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

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

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

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

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

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

The Part D late enrollment penalty is added to your monthly premium (if applicable). Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay your late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium. When you first enroll in our plan, we let you know the amount of the penalty.

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

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

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2018, this average premium amount was $35.02. This amount may change for 2019.
- 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 $35.02, which equals $4.90. 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. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

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

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2019* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

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

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

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

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

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

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

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

Section 6.2 How much is the extra Part D amount?

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

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

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

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

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

SECTION 7 More Information about your monthly premium

Many members are required to pay other Medicare premiums

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

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

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

Your copy of *Medicare & You 2019* gives information about the Medicare premiums in the section called "2019 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2019* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 There are several ways you can pay your plan premium (if applicable)

Your coverage is provided through a contract with the Kansas State Employee Health Plan. For most members, your plan benefits administrator will provide you with information about your plan premium (if applicable). If Aetna bills you directly for your total plan premium, we will mail you a monthly invoice or an annual coupon book detailing your premium amount. (You must also

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

For members who have an Aetna plan premium and are billed directly by Aetna, there are several ways you can pay your plan premium. These options are listed below. You may inform us of your premium payment option choice or change your choice by calling Customer Service at the numbers printed on your member ID card.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

If Aetna bills you directly for your total plan premium, you may decide to pay your monthly plan premium to us by check. Please make your check payable to the plan. Monthly plan premium payments are due the 1st day of each month for coverage of the current month. We must receive your check in our office no later than the 8th of each month to prevent your account from becoming delinquent. All monthly plan premium payments should be sent to the address listed on your monthly invoice or payment coupons.

Coupon Book (if applicable)

Your coupon book should arrive within 30 days of your selection or the date we received your enrollment application. Be sure to include your coupon with your check to ensure the appropriate credit is applied to your account. We reserve the right to charge up to $35 for any returned bank items. In the event that you need a replacement coupon book or you wish to change your payment method, please call Customer Service for assistance (phone numbers are printed on your member ID card).

Option 2: You can pay by automatic withdrawal

If Aetna bills you directly for your total plan premium, you may decide to pay your monthly plan premium by an automatic withdrawal from your bank account by the Electronic Fund Transfer (EFT) option. Your plan premium will be automatically deducted from your bank account by the 10th day of every month. You may also have your plan premium charged to a credit card of your choice and the payment will be charged to your credit card by the 6th day of every month. If you are interested in enrolling in these programs, please contact Customer Service (phone numbers are printed on your member ID card).

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

If you are billed directly by Aetna, your plan premium is due in our office by the first day of the month. If we have not received your premium payment by the tenth day of the month, we will do the following:

- For enrollees who are formally receiving "Extra Help" with payment toward their monthly plan premiums or whose premium payments are made up only of late enrollment penalty amounts, we will send you reminder notices of the premium amounts that are due to help you so you can keep your account up-to-date.
- For all other enrollees, we will send you a notice telling you that your plan membership may end if we do not receive your plan premium within three months of the due date. If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Customer Service are printed on your member ID card.)

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

If we end your membership with the plan because you did not pay your premiums, and you don't currently have prescription drug coverage then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you may need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 7 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling the telephone number printed on your ID card. You may also call our general Customer Service center at 1-844-233-1939 (TTY users should call 711). Hours are 8 a.m. to 6 p.m. local time, Monday through Friday. You must make your request no later than 60 days after the date your membership ends.

Section 7.2 Can we change your monthly plan premium (if applicable) 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 before the change happens and the change will take effect on the date your plan renews.

If your plan requires you to pay a plan premium, 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 all or part of the member's monthly plan premium. If Medicare pays only a portion of this premium your plan administrator will give you additional information on how to pay the amount Medicare does not cover. If Aetna bills you directly we will bill you for the amount Medicare does not cover. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

If your plan does not require you to pay a premium, you may need to start paying or may be able to stop paying a Part D late enrollment penalty. (The Part D late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you ever lose "Extra Help", you must maintain your Part D coverage or you could be subject to a late enrollment penalty.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

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

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number.

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

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on your member ID card).

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

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

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on your member ID card).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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

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

SECTION 10 How other insurance works with our plan

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

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your 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 your family member is still working, their 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 your spouse is still working, their plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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

How to contact our plan's Customer Service

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

Method	Customer Service – Contact Information
CALL	Please call the telephone number printed on your member ID card or our general Customer Service center at 1-844-233-1939. Calls to this number are free. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.
WRITE	Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088
WEBSITE	http://www. AetnaRetireePlans.com

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

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

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

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-414-2386 Calls to this number are free. We're available 8 a.m. to 8 p.m., local time, Monday through Friday.
TTY	711 Calls to this number are free. We're available 8 a.m. to 8 p.m. local time, Monday through Friday.
FAX	1-800-408-2386
WRITE	Aetna P.O. Box 7773 London, KY 40742
WEBSITE	https://www.aetnamedicare.com

How to contact us when you are making an appeal about your Part D prescription drugs

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

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-844-233-1939 Calls to this number are free. We're available 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. We're available 24 hours a day, 7 days a week.
FAX	1-724-741-4954
WRITE	Aetna Medicare Part D Appeals and Grievances P.O. Box 14579 Lexington, KY 40512
WEBSITE	You can submit an appeal online at https://www.aetnamedicare.com

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

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

Method	Complaints about Part D prescription drugs – Contact Information
CALL	Please call the telephone number printed on the back of your member ID card. (If you don't have your ID card, you can call our general customer service center at 1-844-233-1939. However, we recommend you call the number printed on your member ID card.) Calls to this number are free. We're available 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. We're available 24 hours a day, 7 days a week.
FAX	1-724-741-4956
WRITE	Aetna Medicare Part D Grievance & Appeal Unit P.O. Box 14579 Lexington, KY 40512
AETNA WEBSITE	You can submit a complaint about our plan online at https://www.aetnamedicare.com
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Request – Contact Information
WRITE	Aetna Pharmacy Management P.O. Box 52446 Phoenix, AZ 85072-2446

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. **Refer to Addendum A at the back of this *Evidence of Coverage* for the name and contact information for the State Health Insurance Assistance Program in your state.**

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

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

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

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. **Refer to Addendum A at the back of this *Evidence of Coverage* for the name and contact information of the Quality Improvement Organization in your state.**

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

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

SECTION 5 Social Security

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

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

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

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

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

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid agency. **Contact information is in Addendum A in the back of this *Evidence of Coverage*.**

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

Medicare's "Extra Help" Program

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

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

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

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

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

- While you are at the pharmacy, you can ask the pharmacist to contact Aetna at the number on your ID card. If the situation cannot be resolved at that time, Aetna will give you a one-time exception and you will be charged the copayment/coinsurance amount that you were

given by CMS. This exception is temporary and lasts 21 days. Aetna will permanently update our systems upon the receipt of one of the acceptable forms of evidence listed below.

You can send your evidence documentation to Aetna using any of the following contact methods:

Method	Best Available Evidence – Contact Information
WRITE	Aetna Medicare Department Attention: BAE P.O. Box 14088 Lexington, KY 40512-4088
FAX	1-888-665-6296
EMAIL	BAE/LISMailbox@aetna.com

Examples of evidence can be any of the following items:

- A copy of your Medicaid card that includes your name and an eligibility date during a month after June of the previous calendar year
- A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year
- A print out from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year
- A screen print from the state's Medicaid systems showing Medicaid status during a month after June of the previous calendar year
- Other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year
- For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter
- If you are institutionalized and qualify for zero cost-sharing:
    - 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 your behalf to the facility for a full calendar month after June of the previous calendar year

  - A screen print from the state's Medicaid systems showing your 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

- Medicare and additional SSA documents that supports a beneficiary's LIS cost-sharing level:
  - Deeming notice – pub.no. 11166 (purple notice)
  - Auto-enrollment notice – Prospective only pub.no.11154 (yellow notice)
  - Auto-enrollment notice – Retroactive and Prospective pub.no.11429 (yellow notice)
  - Full-facilitated notice – pub.no. 11186 (green notice)
  - Partial-facilitated notice – pub.no.11191 (green notice)
  - Copay change notice – pub.no.11199 (orange notice)
  - Reassignment notice – pub.no. 11208 and 11209 (blue notice)
  - MA Reassignment – pub. no. 11443 (blue notice)
  - LIS Choosers notice – pub. no. 11267 (tan notice)
  - Chooser Reminder notice – pub. no. 11465 (tan notice)

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

Medicare Coverage Gap Discount Program

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

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your *Part D Explanation of Benefits* (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer

count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 63% of the price for generic drugs and you pay the remaining 37% of the price. The coverage for generic drugs works differently than the coverage for brand name drugs. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Your Aetna Medicare Rx (PDP) plan does not have a coverage gap, thus the discounts described here do not apply to you. Instead the plan continues to cover your drugs at your regular cost-sharing amount until you reach the Catastrophic Coverage Stage. Please go to Chapter 4, Section 5 for more information on your cost shares.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on your member ID card).

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

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

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP. **Contact information for your state ADAP is shown on Addendum A attached to this *Evidence of Coverage*.**

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

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

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

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

SECTION 8 How to contact the Railroad Retirement Board

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

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 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	http://www.rrb.gov

SECTION 9 Do you have "group insurance" or other health insurance from another employer/union/trust plan?

You (or your spouse) get benefits from your (or your spouse's) employer or retiree group. Call the Kansas State Employee Health Plan administrator or Customer Service 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 Service are printed on your member ID card.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3

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

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

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

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

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

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

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (https://www.aetnamedicare.com/findpharmacy), or call Customer Service (phone numbers are printed on your member ID card).

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

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on your member ID card) or use the *Pharmacy Directory*. You can also find information on our website at https://www.aetnamedicare.com/findpharmacy.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (*Note*: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Service (phone numbers are printed on your member ID card).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as **"mail-order" (MO) drugs** in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail from our preferred mail-order pharmacy, contact Customer Service (phone numbers are printed on your member ID card).

Usually a mail-order pharmacy order will get to you in no more than 14 days. In the unlikely event that there is a significant delay with your mail-order prescription drug, our mail order service will work with you and a network pharmacy to provide you with a temporary supply of your mail-order prescription drug.

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

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

- You used mail order services with this plan in the past, or

- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling Customer Service (phone numbers are on your member ID card).

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

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Service (phone numbers are on your member ID card).

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. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Customer Service (phone numbers are on your member ID card).

Refills on mail order prescriptions.

For refills of your drugs, you have the option to sign up for an automatic refill program called *AetnaRx Autofill.* Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy *15* days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of *AetnaRx Autofill* that automatically prepares mail order refills, please contact us by calling Customer Service (phone numbers are on your member ID card).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling Customer Service (phone numbers are on your member ID card).

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

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

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information (phone numbers are printed on your member ID card).

2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs available through our plan's mail-order service are marked as **"mail-order" (MO) drugs** in our Drug List. Our plan's mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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

Your prescription may be covered in certain situations

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

- If you are unable to obtain a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.

- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).

- If you are traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.

- If you receive a Part D prescription drug dispensed by an out-of-network institutional-based pharmacy while you are in the emergency department, provider-based clinic, outpatient surgery or other outpatient setting.

- If you have received your prescription during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence.

Out-of-network prescriptions may be limited to a 30-day supply of your drug.

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

How do you ask for reimbursement from the plan?

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

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

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

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

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

The Drug List includes both brand name and generic drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

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

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

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

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

The tier structure for your plan and the amount you pay for covered prescription drugs in each cost-sharing tier is shown in the *Prescription Drug Schedule of Cost Sharing* included with this Evidence of Coverage.

Your tier structure will be the following:

- Tier 1 Preferred Generic Drugs has the lowest cost.
- Tier 2 Generic Drugs has a cost that is usually higher than Tier 1.
- Tier 3 Preferred Brand Drugs* has a cost that is usually higher than Tiers 1 and 2.
- Tier 4 Non-Preferred Drugs* has a cost that is usually higher than Tiers 1, 2 and 3.
- Tier 5 Specialty Tier Drugs has a cost that is usually higher than Tiers 1, 2, 3 and 4.

*Depending on plan type and formulary, in some instances tiers noted with a * may include both brand and higher cost generic drugs. See your *Prescription Drug Schedule of Cost Sharing* for details on your plan coverage.

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

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (http://www.AetnaRetireePlans.com). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on your member ID card.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

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

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

Section 4.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

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

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for

getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on your member ID card) or check our website (http://www.AetnaRetireePlans.com).

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

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

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

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

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts each covered drug into one of a number of different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

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

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

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

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

You may be able to get a temporary supply

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

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

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is **no longer on the plan's Drug List**.

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

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

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

     We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

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

     We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

   - If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with temporary coverage (up to a 31-day supply) for the applicable drug(s).

To ask for a temporary supply, call Customer Service (phone numbers are printed on your member ID card).

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on your member ID card.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that

justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

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

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on your member ID card.)

You can ask for an exception

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

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

Drugs in 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, drugs included under an enhanced drug benefit are not eligible for a tiering exception. (Enhanced drug coverage is offered by some former employer/union/trust plans to cover some prescription drugs not normally covered in a Medicare prescription drug plan. If included, this will be identified on page 1 of your *Prescription Drug Schedule of Cost Sharing* under the section "Enhanced Drug Benefit.")

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

Section 6.1 The Drug List can change during the year

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

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

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

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

Information on changes to drug coverage

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

Do changes to your drug coverage affect you right away?

Changes that can affect you this year:

In the below cases, you will be affected by the coverage changes during the current year:

A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)

We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions.

We may not tell you in advance before we make that change – even if you are currently taking the brand name drug

You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

Unsafe drugs and other drugs on the Drug List that are withdrawn from the market

Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.

Your prescriber will also know about this change, and can work with you to find another drug for your condition.

Other changes to drugs on the Drug List

We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. OR we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' notice or give you a 30-day refill of the drug you are taking at a network pharmacy.

During this 30-day period, you should be working with your prescriber to switch to a different drug that we cover.

Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

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

If any of these changes happens for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

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

Section 7.1 Types of drugs we do not cover

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

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

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

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

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.

- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for the treatment of sexual or erectile dysfunction.
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Customer Service for more information. Phone numbers for Customer Service are printed on your member ID card.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Addendum A at the end of this booklet.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

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

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

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

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

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

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different

drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

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

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

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

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

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

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

Section 9.5 What if you're also getting drug coverage from another employer/union/trust retiree group plan?

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

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

Special note about 'creditable coverage':

If you are covered by another employer/union/trust retiree group plan, each year that employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

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

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you're in Medicare-certified hospice?

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

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

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

The DMP may not apply to you if you have certain medical conditions, such as cancer, or you are receiving hospice care or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) and other programs to help members manage their medications

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

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on your member ID card).

CHAPTER 4

What you pay for your Part D prescription drugs

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

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

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

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the plan's "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Customer Service (phone numbers are printed on your member ID card). You can also find the Drug List on our website at http://www.AetnaRetireePlans.com. The Drug List on the website is always the most current.
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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

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

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

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

Section 2.1 What are the drug payment stages for our plan members?

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

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
The amounts you pay during these stages are listed in *the Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage.*			
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. You stay in this stage until your year-to-date **"out of pocket costs"** (your payments) total $5,100.	Because there is no coverage gap for the plan, this payment stage does not apply to you.	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2019).
(Details are in Section 4 of this chapter.)	(Details are in Section 5 of this chapter.)	(Details are in Section 6 of this chapter.)	(Details are in Section 7 of this chapter.)

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

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

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

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

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

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive an *Part D Explanation of Benefits* (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on your member ID card). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for Aetna Medicare Rx® (PDP)

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

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

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

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

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

The plan has five cost-sharing tiers

- Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug. The tier structure for your plan is listed on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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

Your pharmacy choices

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

- A network retail pharmacy that offers standard cost-sharing
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

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

Section 5.2 Refer to your *Prescription Drug Schedule of Cost Sharing* for a table that shows your costs for a *one-month* supply of a drug

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

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

As shown in the table in the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

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

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

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

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

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

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

Section 5.4 Refer to your *Prescription Drug Schedule of Cost Sharing* for 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") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3, Section 2.4.)

Refer to your *Prescription Drug Schedule of Cost Sharing* for a table that shows your costs for a long-term (up to a 90-day) supply of a drug.

As shown in the table in the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*, the amount of the copayment or coinsurance depends on which tier your drug is in.

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

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $5,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$5,100**. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $5,100, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Your former employer may offer 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 towards your initial coverage limit or total out-of-pocket costs. If included in your plan, this will be listed in your *Prescription Drug Schedule of Cost Sharing* under the section "Enhanced Drug Benefit." To find out which drugs our plan covers, refer to your formulary.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,100 limit in a year.

We will let you know if you reach this $5,100 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,100, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

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

When you add up your out-of-pocket costs, you **can 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 of this booklet):

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

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $5,100 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

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

- The amount you pay for your monthly premium (if applicable).
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan (if offered by the Kansas State Employee Health 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 the Veteran's Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are printed on your member ID card).

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

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report).
- When you reach a total of $5,100 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.

- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 6 There is no Coverage Gap for Aetna Medicare Rx (PDP)

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

There is no coverage gap for Aetna Medicare Rx (PDP). Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

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

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

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,100 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs. The amount you pay during the Catastrophic Coverage Stage is shown on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage.*

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

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

Please note: Certain vaccines, such as Zostavax (Shingles vaccine) are covered under Part D. For vaccines covered under Part D, please refer to your Drug List. For applicable cost sharing, refer to the Prescription Drug Schedule of Cost Sharing included with this EOC. There are two parts to our coverage of Part D vaccinations:

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

What do you pay for a Part D vaccination?

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

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

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

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

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible Stage (if applicable) and Coverage Gap Stage of your benefit (unless the vaccine is included in a drug tier for which plan supplemental coverage is offered).

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

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

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.

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

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

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

Please note: Certain vaccines, such as Zostavax (Shingles vaccine) are covered under Part D. For vaccines covered under Part D, please refer to your Drug List for applicable cost sharing. If you have any questions about how your vaccine is covered, you can call Customer Service (phone numbers are printed on your member ID card).

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on your member ID card.)

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

CHAPTER 5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   - For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

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

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

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on your member ID card.)

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

SECTION 2 How to ask us to pay you back

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

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

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (https://www.aetnamedicare.com/forms) or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on your member ID card.)

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

Aetna Pharmacy Management
P.O. Box 52446
Phoenix, AZ 85072-2446

You must submit your claim to us within 36 months of the date you received the service, item, or Part D drug.

Contact Customer Service if you have any questions (phone numbers are printed on your member ID card). If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal

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

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

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

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

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

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

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

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

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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

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

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

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

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 Customer Service at the number on the back of this booklet. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service for additional information.

Sección 1.1 Debemos proporcionar información de una manera que funcione para usted (en idiomas distintos del inglés, en Braille, en letra grande on en otros formatos alternativos, etc.)

Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios al Cliente (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de intérprete gratuitos disponibles para responder preguntas de los miembros con discapacidades o que no hablan inglés. Muchos documentos también están disponibles en español. También podemos ofrecerle información en Braille, en letra grande, u otros formatos alternativos sin costo alguno, si lo necesita. Tenemos que brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios al Cliente (los números de teléfono están impresos en la contraportada de este folleto) o comuníquese con el Coordinador de Derechos Civiles de Medicare.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, por favor llame para presentar una queja con el departamento de Servicios al Cliente al número que se encuentra en la parte posterior de este folleto. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto se incluye en esta

Evidencia de Cobertura o en este envío, o puede ponerse en contacto con Servicios al Cliente para obtener información adicional.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on your member ID card). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

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

Section 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

Notice of Privacy Practices

Para recibir esta notificación en español por favor llamar al número gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificación.

To receive this notice in Spanish, please call the toll-free Customer Service number on your ID card.

This Notice of Privacy Practices applies to Aetna's insured health benefit plans. It does not apply to any plans that are self-funded by an employer. If you receive benefits through a group health insurance plan, your employer will be able to tell you if your plan is insured or self-funded. If your plan is self-funded, you may want to ask for a copy of your employer's privacy notice.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Aetna[1] considers personal information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information.

When we use the term "personal information," we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care).

This notice became effective on April 26, 2013.

How Aetna Uses and Discloses Personal Information

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and health care providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

Health Care Operations: We may use and disclose personal information during the course of running our health business – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all of the HMO and licensed insurer subsidiaries of Aetna Inc., including but not limited to the entities listed on the last page of this notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). In addition, we make claims information contained on our secure member website and telephonic claims status sites available to the subscriber and all covered dependents. We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, if you receive benefits through a group health insurance plan, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

Additional Reasons for Disclosure

We may use or disclose personal information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to your employer (if you receive your benefits through a group health insurance plan sponsored by your employer), when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.

- **Law Enforcement** – to federal, state and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Health Care

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Customer Service number on your ID card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Customer Service number on your ID card – or have your provider contact us.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

- for marketing purposes that are unrelated to your benefit plan(s),
- before disclosing any psychotherapy notes,
- related to the sale of your health information, and
- for other reasons as required by law.

If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Customer Service number on your ID card.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information:

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information to a different address from that of your subscriber. We will accommodate reasonable requests.

- You have the right to ask us to restrict the way we use or disclose health information about you in connection with health care operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.
- You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews.[2]

You may make any of the requests described above (if applicable), may request a paper copy of this notice, or ask questions regarding this notice by calling the toll-free Customer Service number on your ID card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address:

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079

You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

[2] Aetna does not participate in pretext interviews.

Aetna's Legal Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on your member ID card):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.

  - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are printed on your member ID card) or visit our website at https://www.aetnamedicare.com/findpharmacy.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on your member ID card).

- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your State Health Insurance Assistance Program (SHIP). Contact information is on Addendum A at the back of this booklet.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

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

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on your member ID card).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Customer Service** (phone numbers are printed on your member ID card).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on your member ID card).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare.**

- You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Pubs/pdf/11534.pdf.)
- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on your member ID card). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on your member ID card).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called **"coordination of benefits"** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - **You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.** To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements

- **You have a responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.**
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.**

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums (if applicable) to continue being a member of our plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage* tells what you must pay for your Part D prescription drugs.
  - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on your member ID card).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - **You have a right to make recommendations regarding the organization's member rights and responsibilities policy.**
  - Phone numbers and calling hours for Customer Service are printed on your member ID card.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

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

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BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

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

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

Making an appeal

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

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

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

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

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

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

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

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

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

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

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

Part D coverage decisions and appeals

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

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

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

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

Which of these situations are you in?

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

Section 5.2 What is an exception?

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

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

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the "Drug List" for short.)

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

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the exceptions cost-sharing tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

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

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

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

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

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  - If the drug you're taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name 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 drug cost-sharing tier (if applicable to your plan).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.
- Coverage of any non-formulary drug is not eligible for a tiering exception.
- A drug included under an enhanced drug benefit is not eligible for a tiering exception. (Enhanced drug coverage is offered by some former employer/union/trusts to cover some prescription drugs not normally covered in a Medicare prescription drug plan. If included, this will be identified on page 1 of your *Prescription Drug Schedule of Cost Sharing* under the section "Enhanced Drug Benefit.")

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request that asks us to pay for our share of the cost for a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs*. Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.

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

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

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.

- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
- This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

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

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

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

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

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

What to do

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

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

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

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

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

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

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

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

  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

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

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

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

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

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

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

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

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**

- You have a right to give the Independent Review Organization additional information to support your appeal.

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

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

Deadlines for "fast" appeal at Level 2

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

Deadlines for "standard" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal within 7 calendar days after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **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 your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

- **If the Administrative Law Judge** or attorney adjudicator **says no to your appeal, the appeals process *may* or *may not* be over.**

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

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

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

- **If the answer is no, the appeals process *may* or *may not* be over.**

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

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

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at the plan? ○ Examples include waiting too long on the phone or when getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

Legal Terms
What this section calls a **"complaint"** is also called a **"grievance."** Another term for **"making a complaint"** is **"filing a grievance."** Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Please contact our Customer Service at the number on your member ID card for additional information. (For TTY assistance please call 711.) We're available 24 hours a day, 7 days a week. Calls to these numbers are toll free. Customer Service also has free language interpreter services available for non-English speakers.
- **You can submit a complaint about our plan online.** To submit an online complaint go to: http://www.aetnamedicare.com.
- **If you do not wish to call or submit online (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.
  - Send your written complaint (also known as a grievance) to:

    Aetna Medicare Part D Grievance & Appeal Unit
    P.O. Box 14579
    Lexington, KY 40512
  - Be sure to provide all pertinent information or you may also download the form on our website at https://www.aetnamedicare.com. Under the "Choose a topic to help us find the right process for you" drop down menu, select "Quality of care or other services." This will allow you to select the "How to submit a complaint (grievance)" list which contains our printable complaint form and information on how to submit an online complaint.
  - The grievance must be submitted within 60 days of the event or incident. For written complaints, we will send you a written notice stating the result of our review. This notice will include a description of our understanding of your grievance, and our decision in clear terms. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for an extension or if we identify a need for additional information and the delay is in your best interest.
  - You also have the right to ask for a fast "expedited" grievance. An expedited or "fast" grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a "fast" grievance if you disagree with:
    - Our plan to take a 14-day extension on an organization determination or reconsideration, or

  - Our denial of your request to expedite an organization determination or reconsideration for health services or
  - Our denial of your request to expedite a coverage determination or redetermination for a prescription drug.
  - The expedited/fast complaint (grievance) process is as follows: You or an authorized representative may call or fax your complaint and mention that you want the fast, or expedited, grievance process. Call 1-844-233-1939 or fax your complaint to 1-724-741-4956. Upon receipt of the complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will notify you of our decision by phone within 24 hours and send written follow-up shortly thereafter.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

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

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

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

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Addendum A at the back of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

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

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

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

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

Ending your membership in our plan 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.
  - As a member the Kansas State Employee Health Plan, you may voluntarily end your membership at other times as permitted by your plan sponsor. There are also certain specific times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

It is important that you consider your decision to disenroll from our plan carefully PRIOR to disenrolling. Since disenrollment from our plan could affect your employer or union health benefits, you could permanently lose your employer or union health coverage. If you are considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

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

Because you are enrolled in our plan through the Kansas State Employee Health Plan, you are allowed to make plan changes at other times permitted by your plan sponsor.

If the Kansas State Employee Health Plan holds an annual Open Enrollment Period, you may be able to make a change to your plan coverage at that time. Your plan benefits administrator will let you know when your Open Enrollment Period begins and ends, what plan choices are available to you, and the effective date of coverage.

All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year. Because of your special situation (enrollment through the Kansas State Employee Health Plan) you are eligible to end your membership at any time through a Special Enrollment Period.

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period

Notify your retiree medical benefits plan sponsor's benefits administrator that you would like to disenroll from our plan. The administrator will contact us and we will take the necessary steps to cancel your membership.

If you decide to disenroll from our plan and enroll in an individual Medicare Advantage plan, Original Medicare or another retiree medical benefits administrator-sponsored Medicare Advantage plan, you may want to verify that your disenrollment from our plan aligns with the timeframe for enrolling in the new plan. This will help you avoid a lapse in health care coverage. Enrolling in an individual market Medicare Advantage plan during the general Medicare Advantage Annual Enrollment Period held from October 15 to December 7 will end your membership in this plan.

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.

- **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.

  - If you enroll in most Medicare health plans, you will be disenrolled from our plan when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep our plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

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

It is important that you consider your decision to disenroll from our plan carefully PRIOR to disenrolling. Since disenrollment from our plan could affect your employer or union health benefits, you could permanently lose your employer or union health coverage. If you are considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

Section 2.2 Where can you get more information about when you can end your membership?

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

- You **can call Customer Service** (phone numbers are printed on your member ID card).
- You can find the information in the ***Medicare & You 2019*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

It is important that you consider your decision to disenroll from our plan carefully PRIOR to disenrolling. Since disenrollment from our plan could affect your employer or union health benefits, you could permanently lose your employer or union health coverage. If you are considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

However, there are two situations in which you will need to end your membership in a different way:

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

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

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on your member ID card).
- --*or*--You can contact your benefits administrator.

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

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

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

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

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

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

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

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

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on your member ID card.)
- If you become incarcerated (go to prison).

- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

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

- You can call **Customer Service** for more information (phone numbers are printed on your member ID card).

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

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

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SECTION 3 Notice about Medicare Secondary Payer subrogation rights 133

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SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. 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.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Aetna Medicare Rx (PDP), as a Medicare prescription drug 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.

In some situations, other parties should pay for your prescription drugs before your Medicare Advantage Prescription Drug Plan (PDP). In those situations, your Medicare Prescription Drug plan may pay, but have the right to get the payments back from these other parties. Medicare Prescription Drug plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179)*. You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the http://www.medicare.gov website.

The plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the federal statutes governing the Medicare Program. Your PDP plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your PDP plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

As outlined herein, in these situations, your PDP plan may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your PDP plan shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your PDP plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your PDP plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your PDP plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to

make you whole or to compensate you in part or in whole for the damages you sustained. Your PDP plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your PDP plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The PDP plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your PDP plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist your PDP plan in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing the plan for benefits paid relating to the injury, illness or condition as well as for the plan's reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 4 Notice about recovery of overpayments

If the benefits paid by this *Evidence of Coverage*, plus the benefits paid by other plans, exceeds the total amount of expenses, Aetna has the right to recover the amount of that excess payment from among one or more of the following: (1) any person to or for whom such payments were made; (2) other Plans; or (3) any other entity to which such payments were made. This right of recovery will be exercised at Aetna's discretion. You shall execute any documents and cooperate with Aetna to secure its right to recover such overpayments, upon request by Aetna.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,100 in covered drugs during the covered year.

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

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

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

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

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium, if applicable.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost-sharing

rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

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

Customer Service – 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 Service, or you can call the number printed on your member ID card.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount (if applicable) you must pay for prescriptions before our plan begins to pay.

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

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

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

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

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached $5,100.

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

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

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

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

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

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

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

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

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

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

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the

plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

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

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

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is

available in your state, please contact Customer Service (phone numbers are printed on your member ID card).

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

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

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

Preferred Cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies (if included in your plan).

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a late enrollment penalty.

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

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if you, your doctor, or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

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

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

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

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

prescription drug costs, if you move into a nursing home, if you are a member of our plan through an employer/union/trust group retiree plan, or if we violate our contract with you.

Standard Cost-sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing (if included in your plan) offered at a network pharmacy.

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

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

Addendum A – Important Contact Information for State Agencies

Alabama		
AIDS Drug Assistance Program (ADAP)	**Alabama Department of Public Health** **Alabama AIDS Drug Assistance Program** 201 Monroe St. Ste. 1400 Montgomery, AL 36104 **Fax:** 1-334-206-6221 **Website:** http://www.adph.org/aids	**Toll-free:** 1-866-574-9964 **Local:** 1-334-206-7926 **TTY/TDD:** 711
Alabama		
State Medical Assistance Office	**Alabama Medicaid Agency** 501 Dexter Ave. Montgomery, AL 36104 **Fax:** 1-844-878-7921 **Website:** http://www.medicaid.alabama.gov	**Toll-free:** 1-800-362-1504 **Local:** 1-334-242-5000
Alabama		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Alabama		
SHIP – State Health Insurance Assistance Program	**Alabama Dept of Senior Services** 201 Monroe St. Ste. 350 Montgomery, AL 36104 **Fax:** 1-334-242-5594 **Website:** http://www.alabamaageline.gov	**Toll-free:** 1-800-243-5463 **Local:** 1-334-242-5743 **TTY/TDD:** 711
Alabama		
State Department of Insurance	**Alabama Department of Insurance** P O Box 303351 Montgomery, AL 36130-3351 **Fax:** 1-334-956-7932 **Website:** http://www.aldoi.gov	**Toll-free:** 1-800-433-3966 In State Only **Local:** 1-334-241-4141 **TTY/TDD:** 711

Alabama		
Drug Assistance Program (SPAP)	**SenioRX** **Alabama Dept of Senior Services** 201 Monroe St. Ste. 350 Montgomery, AL 36104 **Fax:** 1-334-242-5594 **Website:** http://www.alabamaageline.gov/	**Toll-free:** 1-800-243-5463 **Local:** 1-334-242-5743 **TTY/TDD:** 711
Alaska		
AIDS Drug Assistance Program (ADAP)	**Alaskan AIDS Assistance Association** 1057 W Fireweed Ln., Ste. 102 Anchorage, AK 99503 **Fax:** 1-907-263-2051 **Website:** http://www.alaskanaids.org	**Toll-free:** 1-800-478-2437 In State Only **Local:** 1-907-263-2050 **TTY/TDD:** 711
Alaska		
Quality Improvement Organization	**Livanta** 10820 Guilford road, Suite 202 Annapolis Junction, MD 20701 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-694-2929 **Website:** http://bfccqioarea5.com	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
Alaska		
SHIP – State Health Insurance Assistance Program	**Medicare Information Office** 400 Gambill Street, Ste 303 Anchorage, AK 99501 **Fax:** 1-907-269-2045 **Website:** http://medicare.alaska.gov	**Toll-free:** 1-800-478-6065 In State Only **Local:** 1-907-269-3680 **TTY/TDD:** 711
Alaska		
State Department of Insurance	**State of Alaska** **Department of Commerce, Community, and Economic Development** **Division of Insurance** 550 West 7th Ave. Suite 1560 Anchorage, AK 99501 **Fax:** 1-907-269-7910 **Website:** https://www.insurance.alaska.gov	**Toll-free:** 1-800-467-8725 In State Only **Local:** 1-907-269-7900 **TTY/TDD:** 711

Alaska		
State Medical Assistance Office	**Department of Health and Social Services – Public Assistance/Conduent Alaska Medicaid** 1835 S. Bragaw St., Ste 200 Anchorage, AK 99508 **Fax:** 1-907-465-3068 **Website:** http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**Toll-free:** 1-800-780-9972 **Local:** 1-907-644-6800 **TTY/TDD:** 1-888-431-5890
Arizona		
AIDS Drug Assistance Program (ADAP)	**Arizona AIDS Drug Assistance Program** 150 N. 18th Ave., Ste. 130 Phoenix, AZ 85007 **Fax:** 1-602-364-3263 **Website:** http://www.azdhs.gov/phs/hiv/adap/index.htm	**Toll-free:** 1-800-334-1540 **Local:** 1-602-364-3610 **TTY/TDD:** 711
Arizona		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6672 **Appeals Fax:** 1-855-694-2929 **Website:** http://bfccqioarea5.com	**Toll-free:** 1-877-588-1123 **TTY/TDD:** 1-855-887-6668
Arizona		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 1789 W. Jefferson St., Site Code 6271 Phoenix, AZ 85007 **Fax:** 1-602-542-6655 **Website:** https://des.az.gov/services/aging-and-adult/state-health-insurance/ship-offices	**Toll-free:** 1-800-432-4040 **Local:** 1-602-542-4446 **TTY/TDD:** 711

Arizona		
State Department of Insurance	**Arizona Department of Insurance** 2910 N. 44th St., Ste. 210 Phoenix, AZ 85018 **Fax:** 1-602-364-2505 **Website:** http://insurance.az.gov	**Toll-free:** 1-800-325-2548 In State Only **Local:** 1-602-364-2499 **TTY/TDD:** 711
Arizona		
State Medical Assistance Office	**Arizona Health Care Cost Containment System (AHCCCS)** 801 E. Jefferson St., Mail Drop 3800 Phoenix, AZ 85034 **Fax:** 1-602-252-6536 **Website:** http://www.azahcccs.gov/	**Toll-free:** 1-855-432-7587 **Local:** 1-602-417-4000 **TTY/TDD:** 711
Arkansas		
AIDS Drug Assistance Program (ADAP)	**Arkansas Department of Health – STI/HIV/Hepatitis C Section AIDS Drug Assistance Program** Arkansas Dept. of Health, 4815 W. Markham St. Little Rock, AR 72205 **Fax:** 1-501-661-2082 **Website:** http://www.healthy.arkansas.gov/programsServices/infectiousDisease/hivStdHepatitisC/Pages/ADAP.aspx	**Toll-free:** 1-888-499-6544 **Local:** 1-501-661-2408 **TTY/TDD:** 711
Arkansas		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776

Arkansas		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Information Program (SHIIP)** 1200 W. Third St., Little Rock, AR 72201 **Fax:** 1-501-371-2781 **Website:** http://insurance.arkansas.gov/shiip.htm	**Toll-free:** 1-800-224-6330 **Local:** 1-501-371-2782 **TTY/TDD:** 711
Arkansas		
State Department of Insurance	**Arkansas Insurance Department Consumer Services Division** 1200 W. Third St., Little Rock, AR 72201 **Fax:** 1-501-371-2618 **Website:** http://www.insurance.arkansas.gov/	**Toll-free:** 1-800-282-9134 **Local:** 1-501-371-2600 **TTY/TDD:** 711
Arkansas		
State Medical Assistance Office	**Arkansas Medicaid** PO Box 1437, Little Rock, AR 72203 **Website:** https://www.medicaid.state.ar.us	**Toll-free:** 1-800-482-5431 **Local:** 1-501-682-8233 **TTY/TDD:** 711
California		
AIDS Drug Assistance Program (ADAP)	**Office of Aids; California Department of Public Health** PO Box 997426, MS 7700, Sacramento, CA 95899-7377 **Fax Appeals**: 1-800-424-5927 **Website:** https://www.cdph.ca.gov/Programs/aids/Pages/OAContactinformation.aspx	**Toll-free:** 1-844-421-7050 **Local:** 1-916-558-1784 **TTY/TDD:** MCI from TDD 1-800-735-2929 or MCI from voice telephone 1-800-735-2922. Sprint from TDD 1-888-877-5378 or Sprint from voice telephone 1-888-877-5379

California		
SHIP – State Health Insurance Assistance Program	**California Health Insurance Counseling & Advocacy Program (HICAP)** 1300 National Dr., Ste. 200 Sacramento, CA 95834 **Fax:** 1-916-928-2267 **Website:** http://www.aging.ca.gov/HICAP	**Toll-free:** 1-800-434-0222 In State Only **Local:** 916-419-7500 **TTY/TDD:** 1-800-735-2929
California		
State Department of Insurance	**California Department of Insurance** 300 S. Spring St, South Tower, Los Angeles, CA 90013 **Fax:** 1-916-445-5280 **Website:** http://www.insurance.ca.gov	**Toll-free:** 1-800-927-4357 In State Only **Local:** 1-213-897-8921 **TTY/TDD:** 1-800-482-4833
California		
State Medical Assistance Office	**Medi-Cal** P.O. Box 997417, MS 4607 Sacramento, CA 95899 **Website:** http://www.medi-cal.ca.gov	**Toll-free:** 1-800-541-5555 In State Only **Local:** 1-916-636-1980 **TTY/TDD:** 711
Colorado		
AIDS Drug Assistance Program (ADAP)	**Colorado Dept of Public Health and Environment AIDS Drug Assistance Program** 4300 Cherry Creek Drive South, A3-3800 Denver, CO 80246 **Fax:** 1-303-691-7736 **Website:** https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap	**Local:** 1-303-692-2000 **TTY/TDD:** 711
Colorado		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776

Colorado		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 1560 Broadway, Suite 850 Denver, CO 80202 **Fax:** 1-303-894-7455 **Website:** https://www.colorado.gov/pacific/dora/senior-healthcare-medicare	**Toll-free:** 1-888-696-7213 **TTY/TDD:** 711
Colorado		
State Pharmaceutical Assistance Program	**Colorado Department of Public Health and Environment** 4300 Cherry Creek Drive, South Denver, CO 80246 **Website:** https://www.colorado.gov/	**Toll-free:** 1-888-696-7213 **Local:** 1-303-692-2783 **TTY/TDD:** 711
Colorado		
State Department of Insurance	**Department of Regulatory Agencies Division of Insurance** 1560 Broadway, Suite 850 Denver, CO 80202 **Website:** www.colorado.gov/pacific/dora/division-insurance	**Toll-free:** 1-800-930-3745 **Local:** 1-303-894-7499 **TTY/TDD:** 711
Colorado		
State Medical Assistance Office	**Health First Colorado Medicaid Program** 1570 Grant Street, Denver, CO 80203 **Fax:** 1-303-866-4411 **Website:** https://www.healthfirstcolorado.com/	**Toll-free:** 1-800-221-3943 **Local:** 1-303-866-2993 **TTY/TDD:** 711
Connecticut		
AIDS Drug Assistance Program (ADAP)	**Connecticut AIDS Drug Assistance Program (CADAP)** Department of Social Services Medical Operations Unit #4, 55 Farmington Avenue Hartford, CT 06105 **Website:** http://www.ct.gov/dss	**Toll-free:** 1-800-233-2503 In State Only **Local:** 1-860-509-8000 Out Of State Only / Dept. Of Public Health **TTY/TDD:** 711

Connecticut		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
Connecticut		
SHIP – State Health Insurance Assistance Program	**CHOICES** 55 Farmington Ave., 12th Floor Hartford, CT 06105 **Fax:** 1-860-424-5301 **Website:** http://www.ct.gov/agingservices	**Toll-free:** 1-800-994-9422 In State Only **Local:** 1-860-424-5274 Out Of State Only **TTY/TDD:** 711
Connecticut		
State Department of Insurance	**Connecticut Insurance Department** 153 Market St., 7th Floor Hartford, CT 06103 **Website:** http://www.ct.gov/cid/site/default.asp	**Toll-free:** 1-800-203-3447 **Local:** 1-860-297-3800 **TTY/TDD:** 711
Connecticut		
State Pharmaceutical Assistance Program	**Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE)** P.O. BOX 5011 Hartford, CT 06102 **Website:** http://www.ct.gov/agingservices/site/default.asp	**Toll-free:** 1-800-423-5026 **Local:** 1-860-269-2029 **TTY/TDD:** 711
Connecticut		
State Medical Assistance Office	**Department of Social Services HUSKY Health Program** 55 Farmington Ave., Hartford, CT 06015 **Website:** http://www.huskyhealth.com	**Toll-free:** 1-855-626-6632 **Local:** 1-877-284-8759 **TTY/TDD:** 711

Delaware		
AIDS Drug Assistance Program (ADAP)	**Delaware HIV Consortium** 100 W. 10th St., Ste. 415 Wilmington, DE 19801 **Fax:** 1-302-654-5472 **Website:** http://www.delawarehiv.org/services/adap/	**Local:** 1-302-654-5471 **TTY/TDD:** 711
Delaware		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Delaware		
SHIP – State Health Insurance Assistance Program	**Delaware Medicare Assistance Bureau** 841 Silver Lake Blvd., Dover, DE 19904 **Fax:** 1-302-736-7979 **Website:** http://insurance.delaware.gov/division/dmab	**Toll-free:** 1-800-336-9500 **Local:** 1-302-674-7364 **TTY/TDD:** 711
Delaware		
State Department of Insurance	**Delaware Department of Insurance** 841 Silver Lake Blvd., Dover, DE 19904 **Fax:** 1-302-739-5280 **Website:** http://insurance.delaware.gov/	**Toll-free:** 1-800-282-8611 **Local:** 1-302-674-7300 **TTY/TDD:** 711
Delaware		
State Medical Assistance Office	**Division of Medicaid & Medical Assistance** 1901 N. Du Pont Highway, PO Box 906, Lewis Bldg. New Castle, DE 19720 **Fax:** 1-302-255-4425 or 1-302-255-4454 **Website:** http://dhss.delaware.gov	**Toll-free:** 1-800-372-2022 **Local:** 1-302-255-9500 **TTY/TDD:** 711

Delaware		
State Pharmaceutical Assistance Program	**Delaware Chronic Renal Disease Program** 11-13 North Church Ave Milford, DE 19963 **Website:** http://www.dhss.delaware.gov/dhss/dmma/crdprog.html	**Toll-free:** 1-800-464-4357 **Local:** 1-302-424-7180 **TTY/TDD:** 711
District of Columbia		
AIDS Drug Assistance Program (ADAP)	**DC AIDS Drug Assistance Program** 899 N. Capitol St. NE, Suite 400 Washington, DC 20002 **Fax:** 1-202-673-4365 **Website:** http://doh.dc.gov/service/dc-aids-drug-assistance-program	**Local:** 1-202-671-4815 **TTY/TDD:** 711
District of Columbia		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
District of Columbia		
SHIP – State Health Insurance Assistance Program	**Health Insurance Counseling Project (HICP)** 650 20th St. NW, Washington, DC 20052 **Fax:** 1-202-293-4043 **Website:** http://dcoa.dc.gov/service/health-insurance	**Local:** 1-202-994-6272 **TTY/TDD:** 711
District of Columbia		
State Department of Insurance	**District of Columbia Insurance, Securities and Banking** 1050 First St. NE, Suite 801 Washington, DC 20002 **Fax:** 1-202-535-1196 **Website:** http://disb.dc.gov/	**Local:** 1-202-727-8000 **TTY/TDD:** 711

District of Columbia		
State Medical Assistance Office	**District of Columbia Medicaid** 441 4th Street, NW, 900S, Washington, DC 20001 **Website:** https://www.dc-medicaid.com/	**Local:** 1-202-727-5355 **TTY/TDD:** 711
Florida		
AIDS Drug Assistance Program (ADAP)	**HIV/AIDS Section** 4052 Bald Cypress Way Tallahassee, FL 32399 **Website:** http://www.floridahealth.gov/diseases-and-conditions/aids/adap	**Toll-free:** 1-800-352-2437 **Local:** 1-850-245-4335 **TTY/TDD:** 711
Florida		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Florida		
SHIP – State Health Insurance Assistance Program	**Florida SHINE** 4040 Esplanade Way, Ste. 270 Tallahassee, FL 32399 **Fax:** 1-850-414-2150 **Website:** http://www.floridaSHINE.org	**Toll-free:** 1-800-963-5337 **TTY/TDD:** 711
Florida		
State Department of Insurance	**Florida Office of Insurance Regulation** 200 E. Gaines St., Tallahassee, FL 32399 **Website:** http://www.floir.com	**Toll-free:** 1-877-693-5236 **Local:** 1-850-413-3140 **TTY/TDD:** 1-800-640-0886
Florida		
State Medical Assistance Office	**Agency for Health Care Administration** 2727 Mahan Dr., Mail Stop #58 Tallahassee, FL 32308 **Website:** http://ahca.myflorida.com/	**Toll-free:** 1-888-419-3456 **Local:** 1-850-487-1111 **TTY/TDD:** 711

Georgia		
AIDS Drug Assistance Program (ADAP)	**Georgia DHR, Division of Public Health – Georgia Department of Human Services: ADAP/HICP Manager** 2 Peachtree St. NW, 12th Floor Atlanta, GA 30303 **Website:** http://dph.georgia.gov/adap-program	**Local:** 1-404-657-3100 **TTY/TDD:** 711
Georgia		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Georgia		
SHIP – State Health Insurance Assistance Program	**GeorgiaCares** 2 Peachtree St. NW, 33rd Floor Atlanta, GA 30303 **Website:** http://www.mygeorgiacares.org	**Toll-free:** 1-866-552-4464 **TTY/TDD:** 711
Georgia		
State Department of Insurance	**Office of Insurance and Safety Fire Commissioner** 2 Martin Luther King Jr. Dr., West Tower, Ste. 704 Atlanta, GA 30334 **Fax:** 1-404-657-8542 **Website:** http://www.oci.ga.gov	**Toll-free:** 1-800-656-2298 **Local:** 1-404-656-2070 **TTY/TDD:** 711
Georgia		
State Medical Assistance Office	**Georgia Department of Community Health** 2 Peachtree St. NW, Atlanta, GA 30303 **Website:** http://dch.georgia.gov/medicaid	**Toll-free:** 1-866-211-0950 **Local:** 1-404-656-4507 **TTY/TDD:** 711

Hawaii		
AIDS Drug Assistance Program (ADAP)	**HIV Drug Assistance Program** 3627 Kilauea Ave., Ste. 306 Honolulu, HI 96816 **Website:** http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/	**Local:** 1-808-733-9360 **TTY/TDD:** 711
Hawaii		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6672 **Appeals Fax:** 1-855-694-2929 **Website:** http://bfccqioarea5.com	**Toll-free:** 1-877-588-1123 **TTY/TDD:** 1-855-887-6668
Hawaii		
SHIP – State Health Insurance Assistance Program	**Hawaii SHIP** No. 1 Capitol District, 250 S. Hotel St. Ste. 406 Honolulu, HI 96813 **Fax:** 1-808-586-0185 **Website:** http://hawaiiship.org	**Toll-free:** 1-888-875-9229 **Local:** 1-808-586-7299 **TTY/TDD:** 711
Hawaii		
State Department of Insurance	**Department of Commerce and Consumer Affairs, Insurance Division** 335 Merchant St., Rm. 213 Honolulu, HI 96813 **Fax:** 1-808-586-2806 **Website:** http://cca.hawaii.gov/ins/	**Local:** 1-808-586-2790 **TTY/TDD:** 711
Hawaii		
State Medical Assistance Office	**Dept. of Human Services of Hawaii, Med-Quest Division** PO Box 700190, Kapolei, HI 96709 **Fax:** 1-808-587-3543 **Website:** http://humanservices.hawaii.gov/mqd	**Toll-free:** 1-800-316-8005 **Local:** 1-808-524-3370 **TTY/TDD:** 711

Idaho		
AIDS Drug Assistance Program (ADAP)	**IDAGAP (Idaho AIDS Drug Assistance Program)** 450 W. State St., PO Box 83720 Boise, ID 83720 **Fax:** 1-208-332-7346 **Website:** http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	**Local:** 1-208-334-5612 **TTY/TDD:** 711
Idaho		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6672 **Appeals Fax:** 1-855-694-2929 **Website:** http://bfccqioarea5.com	**Toll-free:** 1-877-588-1123 **TTY/TDD:** 1-855-887-6668
Idaho		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Benefit Advisors (SHIBA)** 700 W. State St., 3rd floor PO Box 83720 Boise, ID 83720 **Fax:** 1-208-334-4389 **Website:** http://www.doi.idaho.gov/shiba/	**Toll-free:** 1-800-247-4422 **TTY/TDD:** 711
Idaho		
State Department of Insurance	**Idaho Department of Insurance** 700 W. State St., 3rd Floor, PO Box 83720 Boise, ID 83720 **Fax:** 1-208-334-4398 **Website:** http://doi.idaho.gov/	**Toll-free:** 1-800-721-3272 In State Only **Local:** 1-208-334-4250 **TTY/TDD:** 711
Idaho		
State Medical Assistance Office	**Department of Health and Welfare: Idaho Medicaid Program** PO Box 83720, Boise, ID 83720 **Fax:** 1-866-434-8278 **Website:** idalink.idaho.gov	**Toll-free:** 1-877-456-1233 **Local:** 1-208-334-6700 **TTY/TDD:** 711

Idaho		
State Pharmaceutical Assistance Program	**Idaho AIDS Drug Assistance Program (IDAGAP)** PO Box 83720 Boise, ID 83720 **Fax:** 1-208-334-5531 **Website:** http://www.211.idaho.gov/	**Toll-free:** 1-800-926-2588 **Local:** 1-208-334-5943 **TTY/TDD:** 711
Illinois		
AIDS Drug Assistance Program (ADAP)	**Illinois Dept of Public Health – AIDS Drug Assistance Program: ADAP Administrator** 535 W. Jefferson Street, First Floor Springfield, IL 62761 **Fax:** 1-217-785-8013 **Website:** http://www.idph.state.il.us/health/aids/adap.htm	**Toll-free:** 1-800-825-3518 In State Only **Local:** 1-217-782-4977 **TTY/TDD:** 1-800-547-0466
Illinois		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Illinois		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Program (SHIP)** One Natural Resources Way, Suite 100 Springfield, IL 62702 **Fax:** 1-217-785-4477 **Website:** http://www.illinois.gov/aging/ship/Pages/default.aspx	**Toll-free:** 1-800-252-8966 **TTY/TDD:** 711
Illinois		
State Department of Insurance	**Illinois Department of Insurance** 320 West Washington St., Springfield, IL 62767 **Website:** http://insurance.illinois.gov/	**Toll-free:** 1-877-527-9431 **Local:** 1-217-782-4515 **TTY/TDD:** 1-217-782-5020

Illinois		
State Medical Assistance Office	**Illinois Department of Healthcare and Family Services (Medicaid)** 401 South Clinton Street, 6th Floor Chicago, IL 60607 **Website:** http://www2.illinois.gov/hfs/Pages/default.aspx	**Toll-free:** 1-800-226-0768 **Local:** 1-217-782-4977 **TTY/TDD:** 1-800-447-6404
Indiana		
AIDS Drug Assistance Program (ADAP)	**Indiana State Department of Health AIDS Drug Assistance Plan** 2 N. Meridian St., Indianapolis, IN 46204 **Website:** http://www.in.gov/isdh/17740.htm	**Toll-free:** 1-866-588-4948 **Local:** 1-317-233-7450 **TTY/TDD:** 711
Indiana		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Indiana		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 311 West Washington Street, Suite 300 Indianapolis, IN 46204 **Website:** http://www.medicare.in.gov	**Toll-free:** 1-800-452-4800 **Local:** 1-765-608-2318 **TTY/TDD:** 1-866-846-0139
Indiana		
State Department of Insurance	**Indiana Department of Insurance** 311 W. Washington St., Suite 300 Indianapolis, IN 46204 **Fax:** 1-317-232-5251 **Website:** http://www.in.gov/idoi	**Toll-free:** 1-800-622-4461 **Local:** 1-317-232-2385 **TTY/TDD:** 711

Indiana		
State Medical Assistance Office	**Indiana Family and Social Services Administration** 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207 **Website:** http://indianmedicaid.com	**Toll-free:** 1-800-403-0864 **Local:** 1-317-713-9627 **TTY/TDD:** 711
Indiana		
State Pharmaceutical Assistance Program	**HoosierRx** PO Box 6224, Indianapolis, IN 46206 **Fax:** 1-317-234-3709 **Website:** http://www.in.gov/fssa/elderly/hoosierrx	**Toll-free:** 1-866-267-4679 **Local:** 1-317-234-1381 **TTY/TDD:** 711
Iowa		
AIDS Drug Assistance Program (ADAP)	**Iowa Dept of Public Health – Bureau of HIV, STD and Hepatitis: ADAP Coordinator** 321 East 12th Street, Des Moines, IA 50319 **Fax:** 1-515-725-2011 **Website:** http://idph.iowa.gov/hivstdhep/hiv/support	**Local:** 1-515-281-0926 **TTY/TDD:** 711
Iowa		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776

Iowa		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Information Program (SHIIP)** 601 Locust St. 4th floor, Two Ruan Center Des Moines, IA 50309 **Website:** http://www.shiip.state.ia.us/	**Toll-free:** 1-800-351-4664 **TTY/TDD:** 1-800-735-2942
Iowa		
State Department of Insurance	**Iowa Insurance Division** 601 Locust St. 4th Floor, Two Ruan Center Des Moines, IA 50309 **Website:** http://www.iid.state.ia.us	**Toll-free:** 1-877-955-1212 In State Only **Local:** 1-515-281-5705 Des Moines **TTY/TDD:** 711
Iowa		
State Medical Assistance Office	**Iowa Department of Human Services (DHS) – Iowa Medicaid Enterprise (IME)** P.O. Box 36510, Des Moines, IA 50315 **Fax:** 1-515-725-1351 **Website:** http://dhs.iowa.gov/	**Toll-free:** 1-800-338-8366 **Local:** 1-515-256-4606 **TTY/TDD:** 711
Kansas		
AIDS Drug Assistance Program (ADAP)	**Kansas Dept of Health and Environment – STI/HIV Section: AIDS Drug Assistance Program Coordinator** 1000 SW Jackson, Suite 210 Topeka, KS 66612 **Fax:** 1-785-559-4225 **Website:** http://www.kdheks.gov/sti_hiv/ryan_white_care.htm	**Local:** 1-785-296-6174 **TTY/TDD:** 711
Kansas		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776

Kansas		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Counseling for Kansas (SHICK)** 503 S. Kansas Avenue, Topeka, KS 66603 **Fax:** 1-785-296-0256 **Website:** http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick	**Toll-free:** 1-800-860-5260 **Local:** 1-785-291-3357 **TTY/TDD:** 711
Kansas		
State Department of Insurance	**Kansas Insurance Department** 420 SW 9th Street, Topeka, KS 66612 **Fax:** 1-785-296-5806 **Appeals Fax:** **Website:** http://www.ksinsurance.org/	**Toll-free:** 1-800-432-2484 In State Only **Local:** 1-785-296-7829 **TTY/TDD:** 711
Kansas		
State Medical Assistance Office	**KanCare-Kansas Medicaid Program** PO Box 3599, Topeka, KS 66601 **Fax:** 1-800-498-1255 **Website:** http://www.kancare.ks.gov/	**Toll-free:** 1-800-792-4884 **TTY/TDD:** 711
Kentucky		
AIDS Drug Assistance Program (ADAP)	**Kentucky Department for Public Health – Cabinet for Health & Family Services, Division of Epidemiology: KADAP Coordinator** 275 E. Main St., Mail Stop HS2E-C#980 Frankfort, KY 40621 **Fax:** 1-877-353-9380 **Website:** http://chfs.ky.gov/dph/epi/hivaids/services.htm	**Toll-free:** 1-866-510-0005 **Local:** 1-502-564-6539 **TTY/TDD:** 711

Kentucky		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Kentucky		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 275 E. Main St., 3E-E, Frankfort, KY 40621 **Website:** http://www.chfs.ky.gov/dail/ship.htm	**Toll-free:** 1-877-293-7447 **Local:** 1-502-564-6930 **TTY/TDD:** 711
Kentucky		
State Department of Insurance	**Kentucky Department of Insurance** P.O. Box 517, Frankfort, KY 40602 **Website:** http://insurance.ky.gov/	**Toll-free:** 1-800-595-6053 **Local:** 1-502-564-3630 **TTY/TDD:** 1-800-648-6056
Kentucky		
State Medical Assistance Office	**Kentucky Department for Medicaid Services** 275 E. Main St., Frankfort, KY 40621 **Website:** http://www.chfs.ky.gov/dms	**Toll-free:** 1-800-635-2570 **Local:** 1-502-564-4321 **TTY/TDD:** 711
Louisiana		
AIDS Drug Assistance Program (ADAP)	**Louisiana Health Access Program (LA HAP)** 1450 Poydras Street, Ste. 2136 New Orleans, LA 70112 **Fax:** 1-504-568-3157 **Website:** http://www.lahap.org	**Local:** 1-504-568-7474 **TTY/TDD:** 711

Louisiana		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Louisiana		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Information Program (SHIIP)** P.O. Box 94214 Baton Rouge, LA 70804 **Fax:** 1-225-342-3078 **Website:** http://www.ldi.la.gov/SHIIP	**Toll-free:** 1-800-259-5300 **Local:** 1-225-342-5301 **TTY/TDD:** 1-800-325-0778
Louisiana		
State Department of Insurance	**Louisiana Department of Insurance** 1702 N. Third Street Baton Rouge, LA 70802 **Fax:** 1-225-342-3078 **Website:** http://www.ldi.state.la.us/	**Toll-free:** 1-800-259-5300 **Local:** 1-225-342-5900 **TTY/TDD:** 711
Louisiana		
State Medical Assistance Office	**Louisiana Department of Health – Louisiana Medicaid** PO Box 629 Baton Rouge, LA 70821 **Fax:** 1-877-523-2987 **Website:** http://ldh.louisiana.gov/index.cfm/subhome/1	**Toll-free:** 1-888-342-6207 **TTY/TDD:** 711
Maine		
AIDS Drug Assistance Program (ADAP)	**Positive Maine** 286 Water St., 11 State House Station, Augusta, ME 04333 **Fax:** 1-207-287-3498 **Website:** http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml	**Local:** 1-207-287-3747 **TTY/TDD:** 711

Maine		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
Maine		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 41 Anthony Ave., Augusta, ME 04333 **Fax:** 1-207-287-9229 **Website:** http://www.maine.gov/dhhs/oads/index.html	**Toll-free:** 1-800-262-2232 **TTY/TDD:** 711
Maine		
State Department of Insurance	**Department of Professional and Financial Regulation** **Maine Bureau of Insurance** 34 State House Station, Augusta, ME 04333 **Fax:** 1-207-624-8599 **Website:** http://www.maine.gov/insurance	**Toll-free:** 1-800-300-5000 **Local:** 1-207-624-8475 **TTY/TDD:** 711
Maine		
State Medical Assistance Office	**MaineCare** 114 Corn Shop lane, Farmington, ME 04938 **Fax:** 1-207-778-8429 **Website:** http://www.maine.gov/dhhs/oms/member/	**Toll-free:** 1-800-977-6740 **TTY/TDD:** 711

Maine		
State Pharmaceutical Assistance Program	**Maine Rx Plus / Maine Low Cost Drugs for the Elderly or Disabled Program** 242 State St., Augusta, ME 04333 **Fax:** 1-207-287-8601 **Website:** http://www.maine.gov/dhhs/oads/	**Toll-free:** 1-866-796-2463 **TTY/TDD:** 711
Maryland		
AIDS Drug Assistance Program (ADAP)	**Maryland Department of Health and Mental Hygiene – AIDS Administration and Client Services: Deputy Chief for Client Services** 500 N. Calvert Street, Baltimore, MD 21202 **Fax:** 1-410-333-2608 **Website:** http://phpa.dhmh.maryland.gov/OIDPCS/CHCS/pages/madap.aspx	**Toll-free:** 1-800-205-6308 **Local:** 1-410-767-6535 **TTY/TDD:** 711
Maryland		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Maryland		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 301 West Preston Street, Suite 1007 Baltimore, MD 21201 **Fax:** 1-410-333-7943 **Website:** http://www.aging.maryland.gov	**Toll-free:** 1-800-243-3425 **Local:** 1-410-767-1100 **TTY/TDD:** 711

Maryland		
State Department of Insurance	**Maryland Insurance Administration** 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 **Fax:** 1-410-468-2270 **Website:** http://www.mdinsurance.state.md.us/	**Toll-free:** 1-800-492-6116 **Local:** 1-410-468-2000 **TTY/TDD:** 1-800-735-2258
Maryland		
State Medical Assistance Office	**Maryland Department of Health and Mental Hygiene** 201 West Preston Street, Baltimore, MD 21201 **Website:** https://mmcp.dhmh.maryland.gov/SitePages/Home.aspx	**Toll-free:** 1-877-463-3464 **Local:** 1-410-767-6500 **TTY/TDD:** 711
Maryland		
State Pharmaceutical Assistance Program	**Maryland Senior Prescription Drug Assistance Program (SPDAP)** 628 Hebron Avenue, Suite 502 Glastonbury, CT 06033 **Fax:** 1-800-847-8217 **Website:** http://marylandspdap.com	**Toll-free:** 1-800-551-5995 **TTY/TDD:** 1-800-877-5156
Massachusetts		
AIDS Drug Assistance Program (ADAP)	**Office of HIV/AIDS – HDAP: Coordinator** 38 Chauncy St., Suite 500 Boston, MA 02111 **Fax:** 1-617-502-1703 **Website:** http://www.mass.gov/eohhs/gov/departments/dph/programs/id/hiv-aids/	**Toll-free:** 1-800-228-2714 **Local:** 1-617-502-1700 **TTY/TDD:** 711
Massachusetts		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289

Massachusetts		
SHIP – State Health Insurance Assistance Program	**Serving Health Information Needs of Elders (SHINE)** One Ashburton Place, 5th Floor Boston, MA 02108 **Fax:** 1-617-727-9368 **Website:** http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html	**Toll-free:** 1-800-243-4636 **Local:** 1-617-727-7750 **TTY/TDD:** 711
Massachusetts		
State Department of Insurance	**Office of Consumer Affairs and Business Regulation** **Massachusetts Division of Insurance** 1000 Washington St, Suite 810 Boston, MA 02118 **Website:** http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/	**Toll-free:** 1-877-563-4467 **Local:** 1-617-521-7794 **TTY/TDD:** 711
Massachusetts		
State Medical Assistance Office	**Office of Health and Human Services of Massachusetts** One Ashburton Place, 11th Floor Boston, MA 02108 **Website:** http://www.mass.gov/masshealth	**Toll-free:** 1-800-841-2900 **Local:** 1-617-847-3700 **TTY/TDD:** 711
Massachusetts		
State Pharmaceutical Assistance Program	**Massachusetts Prescription Advantage** P.O. Box 15153, Worcester, MA 01615 **Website:** http://www.mass.gov/elders/healthcare/prescription-advantage/prescription-advantage-overview.html	**Toll-free:** 1-800-243-4636 **TTY/TDD:** 711

Michigan		
AIDS Drug Assistance Program (ADAP)	**Michigan Department of Community Health: ADAP Coordinator** 109 Michigan Avenue, 9th Floor Lansing, MI 48913 **Fax:** 1-517-335-7723 **Website:** http://www.michigan.gov/mdhhs/	**Toll-free:** 1-888-826-6565 **TTY/TDD:** 711
Michigan		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Michigan		
SHIP – State Health Insurance Assistance Program	**MMAP, Inc.** 6105 W. St. Joseph Hwy., #204 Lansing, MI 48917 **Fax:** 1-517-373-4092 **Website:** http://mmapinc.org	**Toll-free:** 1-800-803-7174 **TTY/TDD:** 711
Michigan		
State Department of Insurance	**Department of Insurance and Financial Services** P.O. Box 30220, Lansing, MI 48909 **Fax:** 1-517-284-8837 **Website:** http://www.michigan.gov/difs	**Toll-free:** 1-877-999-6442 **Local:** 1-517-284-8800 **TTY/TDD:** 711
Michigan		
State Medical Assistance Office	**Michigan Department Community Health** 201 Townsend Street, Lansing, MI 48913 **Website:** http://www.michigan.gov/mdch	**Toll-free:** 1-800-642-3195 **Local:** 1-517-373-3740 **TTY/TDD:** 711

Minnesota		
AIDS Drug Assistance Program (ADAP)	**Minnesota Department of Human Services – HIV/AIDS Unit: Program Administrator** MDHS Program HH P.O. Box 64972, St. Paul, MN 55164 **Fax:** 1-651-431-7414 **Website:** http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp	**Toll-free:** 1-800-657-3761 **Local:** 1-651-431-2414 **TTY/TDD:** 711
Minnesota		
SHIP – State Health Insurance Assistance Program	**Minnesota State Health Insurance Assistance Program/Senior LinkAge Line** 2365 N McKnight Rd., St. Paul, MN 55109 **Website:** http://www.mnaging.org/	**Toll-free:** 1-800-333-2433 **TTY/TDD:** 711
Minnesota		
State Department of Insurance	**Department of Commerce of Minnesota** 85 7th Place East, Suite 500 St Paul, MN 55101 **Fax:** 1-651-539-1547 **Website:** http://www.commerce.state.mn.us/	**Toll-free:** 1-800-657-3602 **Local:** 1-651-539-1500 **TTY/TDD:** 711
Minnesota		
State Medical Assistance Office	**Department of Human Services of Minnesota – MinnesotaCare** PO Box 64838, St Paul, MN 55164 **Website:** http://mn.gov/dhs/	**Toll-free:** 1-800-657-3672 **Local:** 1-651-431-2801 **TTY/TDD:** 711

Mississippi		
AIDS Drug Assistance Program (ADAP)	**Mississippi Department of Health – Care and Services Division, Office of STD/HIV: ADAP Director** 570 East Woodrow Wilson, Jackson, MS 39215 **Fax:** 1-601-362-4782 **Website:** http://msdh.ms.gov/msdhsite/_static/14,13047,150.html	**Toll-free:** 1-888-343-7373 **Local:** 1-601-362-4879 **TTY/TDD:** 711
Mississippi		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Mississippi		
SHIP – State Health Insurance Assistance Program	**MS State Health Insurance Assistance Program (SHIP)** 200 S Lamar Street Jackson, MS 39201 **Website:** http://www.mdhs.state.ms.us/programs-and-services-for-seniors/state-health-insurance-assistance-program/	**Toll-free:** 1-844-822-4622 **Local:** 1-601-359-4366 **TTY/TDD:** 711
Mississippi		
State Department of Insurance	**Mississippi Insurance Department** P.O. Box 79, Jackson, MS 39205 **Fax:** 1-601-359-1077 **Website:** http://www.mid.ms.gov/	**Toll-free:** 1-800-562-2957 **Local:** 1-601-359-3569 **TTY/TDD:** 711
Mississippi		
State Medical Assistance Office	**Mississippi Division of Medicaid** 550 High Street, Suite 1000 Jackson, MS 39201 **Fax:** 1-601-359-6294 **Website:** https://www.medicaid.ms.gov/	**Toll-free:** 1-800-421-2408 **Local:** 1-601-359-6050 **TTY/TDD:** 711

Missouri		
AIDS Drug Assistance Program (ADAP)	**Missouri Department of Health and Senior Services – Prevention and Care Programs, Section of Communicable Disease Prevention: HIV Care Coordinator** 930 Wildwood Drive, Jefferson City, MO 65109 **Fax:** 1-573-751-6447 **Website:** http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	**Toll-free:** 1-866-628-9891 **Local:** 1-573-751-6439 **TTY/TDD:** 711
Missouri		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Missouri		
SHIP – State Health Insurance Assistance Program	**CLAIM** 200 N. Keene St., Suite 101 Columbia, MO 65201 **Website:** http://www.missouriclaim.org	**Toll-free:** 1-800-390-3330 **Local:** 1-573-817-8320 **TTY/TDD:** 711
Missouri		
State Department of Insurance	**Missouri Department of Insurance** PO Box 690, Jefferson City, MO 65102 **Fax:** 1-573-526-4898 **Website:** http://www.insurance.mo.gov	**Toll-free:** 1-800-726-7390 **Local:** 1-573-751-4126 **TTY/TDD:** 711
Missouri		
State Medical Assistance Office	**Missouri Department of Social Services MO HealthNet Division** P.O. Box 6500 Jefferson City, MO 65102 **Fax:** 1-573-751-6564 **Website:** http://www.dss.mo.gov/mhd/	**Toll-free:** 1-800-392-2161 **Local:** 1-573-751-3425 **TTY/TDD:** 711

Missouri		
State Pharmaceutical Assistance Program	**Missouri Rx Plan** P.O. Box 6500 Jefferson City, MO 65102 **Website:** https://dss.mo.gov/morx/	**Toll-free:** 1-800-375-1406 **TTY/TDD:** 711
Montana		
AIDS Drug Assistance Program (ADAP)	**Montana Dept. of Public Health and Human Services – STD/HIV Section: Manager** 1400 Broadway, Cogswell Building, Room C211 Helena, MT 59620 **Fax:** 1-406-444-6842 **Website:** http://dphhs.mt.gov/publichealth/hivstd.aspx	**Local:** 1-406-444-4744 **TTY/TDD:** 711
Montana		
SHIP – State Health Insurance Assistance Program	**Montana State Health Insurance Assistance Program (SHIP)** 2030 – 11th Ave, Helena, MT 59604 **Website:** http://dphhs.mt.gov/SLTC/services/aging/SHIP	**Toll-free:** 1-800-551-3191 **TTY/TDD:** 711
Montana		
State Department of Insurance	**Commissioner of Securities and Insurance – Consumer Service Division** 840 Helena Ave., Helena, MT 59601 **Fax:** 1-406-444-3497 **Website:** http://csimt.gov/your-insurance/health/	**Toll-free:** 1-800-332-6148 **Local:** 1-406-444-2040 **TTY/TDD:** 1-406-444-3426
Montana		
State Medical Assistance Office	**Montana Medicaid** 2030 11th Avenue, Helena, MT 59601 **Website:** http://www.dphhs.mt.gov	**Toll-free:** 1-800-362-8312 **TTY/TDD:** 711

Montana		
State Pharmaceutical Assistance Program	**Montana Big Sky Rx Program** P.O. Box 202915, Helena, MT 59620 **Fax:** 1-406-444-3846 **Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx	**Toll-free:** 1-866-369-1233 **Local:** 1-406-444-1233 **TTY/TDD:** 711
Nebraska		
AIDS Drug Assistance Program (ADAP)	**Nebraska Department of Health and Human Services – Infectious Diseases Prevention: ADAP Coordinator** 988106 Nebraska Medical Center, Omaha, NE 68198 **Fax:** 1-402-553-5527 **Website:** http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_white.aspx	**Toll-free:** 1-866-632-2437 **Local:** 1-402-559-4673 **TTY/TDD:** 711
Nebraska		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Nebraska		
SHIP – State Health Insurance Assistance Program	**Nebraska Senior Health Insurance Information Program (SHIIP)** 941 O Street Suite 400 Lincoln, NE 68508 **Website:** http://www.doi.nebraska.gov/shiip/	**Toll-free:** 1-800-234-7119 **Local:** 1-402-471-2201 **TTY/TDD:** 711
Nebraska		
State Department of Insurance	**Nebraska Department of Insurance** 941 O Street Suite 220, P.O. Box 82089, Lincoln, NE 68501 **Website:** http://www.doi.nebraska.gov/	**Toll-free:** 1-877-564-7323 In State Only **Local:** 1-402-471-2201 **TTY/TDD:** 711

Nebraska		
State Medical Assistance Office	**Nebraska Department of Health and Human Services System** 301 Centennial Mall South, Lincoln, NE 68509 **Website:** www.Accessnebraska.ne.gov	**Toll-free:** 1-855-632-7633 **Local:** 1-402-471-3121 **TTY/TDD:** 711
Nevada		
AIDS Drug Assistance Program (ADAP)	**Department of Human Resources – Communicable Disease Program, Bureau of Community Health: ADAP Coordinator** 4001 S. Virginia St., Suite F. Reno, NV 89502 **Fax:** 1-775-684-4056 **Website:** http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home	**Toll-free:** 1-877-385-2345 **Local:** 1-775-284-8989 **TTY/TDD:** 711
Nevada		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** 3416 Goni Road, Suite D-132 Carson City, NV 89706 **Website:** http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	**Toll-free:** 1-800-307-4444 **Local:** 1-702-486-3478 **TTY/TDD:** 711
Nevada		
State Department of Insurance	**Nevada Department of Business and Industry – Division of Insurance** 1818 E. College Pkwy, Ste. 103 Carson City, NV 89706 **Fax:** 1-775-687-0787 **Website:** http://doi.state.nv.us/	**Toll-free:** 1-888-872-3234 **Local:** 1-775-687-0700 **TTY/TDD:** 711
Nevada		
State Medical Assistance Office	**Nevada Department of Health and Human Services** 1210 S. Valley View, Suite 104 Las Vegas, NV 89102 **Website:** http://dhhs.nv.gov/	**Toll-free:** 1-800-992-0900 **Local:** 1-702-668-4200 **TTY/TDD:** 711

Nevada		
State Pharmaceutical Assistance Program	**Nevada Senior Rx Program – Department of Health and Human Services** 3416 Goni Road, Suite D-132 Carson City, NV 89706 **Fax:** 1-775-687-0576 **Website:** http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/	**Toll-free:** 1-866-303-6323 **Local:** 1-775-687-4210 **TTY/TDD:** 711
New Hampshire		
AIDS Drug Assistance Program (ADAP)	**New Hampshire Dept of Health and Human Services** 29 Hazen Drive, Concord, NH 03301 **Fax:** 1-603-271-4934 **Website:** http://www.dhhs.nh.gov/dphs/bchs/std/care.htm	**Toll-free:** 1-800-852-3345 (In State Only) **Local:** 1-603-271-4502 **TTY/TDD:** 711
New Hampshire		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
New Hampshire		
SHIP – State Health Insurance Assistance Program	**NH SHIP – ServiceLink Resource Center** 67 Water St., Suite 105 Laconia, NH 03246 **Website:** www.servicelink.nh.gov	**Toll-free:** 1-866-634-9412 **TTY/TDD:** 711
New Hampshire		
State Department of Insurance	**New Hampshire Insurance Department** 21 South Fruit Street, Suite 14 Concord, NH 03301 **Fax:** 1-603-271-1406 **Website:** http://www.nh.gov/insurance	**Toll-free:** 1-800-852-3416 **Local:** 1-603-271-2261 **TTY/TDD:** 1-800-735-2964

New Hampshire		
State Medical Assistance Office	**NH Medicaid** 129 Pleasant St., Main Building Concord, NH 03301 **Fax:** 1-603-271-4230 **Website:** https://www.dhhs.nh.gov/ombp/medicaid/index.htm	**Toll-free:** 1-800-852-3345 Ext. 4344 **Local:** 1-603-271-4344 **TTY/TDD:** 1-800-735-2964
New Jersey		
AIDS Drug Assistance Program (ADAP)	**New Jersey Department of Health and Senior Services – Division of HIV/AIDS Services: Coordinator Primary and Preventive Health Services** PO Box 360, Trenton, NJ 08625 **Fax:** 1-609-588-7037 **Website:** http://www.state.nj.us/health/	**Toll-free:** 1-877-613-4533 **Local:** 1-609-588-7038 **TTY/TDD:** 711
New Jersey		
Quality Improvement Organization	**Livanta** 10820 Guilford Drive, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
New Jersey		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** PO Box 715, Trenton, NJ 08625 **Website:** http://www.state.nj.us/humanservices/doas/services/ship/	**Toll-free:** 1-800-792-8820 **TTY/TDD:** 711

New Jersey		
State Department of Insurance	**State of New Jersey – Department of Banking and Insurance** 20 West State Street, PO Box 325 Trenton, NJ 08625 **Fax:** 1-609-984-5263 **Website:** http://www.state.nj.us/dobi/index.html	**Toll-free:** 1-800-446-7467 **Local:** 1-609-292-7272 **TTY/TDD:** 711
New Jersey		
State Medical Assistance Office	**Division of Medical Assistance and Health Services** PO Box 712, Trenton, NJ 08625 **Website:** http://www.state.nj.us/humanservices/dmahs	**Toll-free:** 1-800-356-1561 **TTY/TDD:** 711
New Jersey		
State Pharmaceutical Assistance Program	**New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)** P.O. Box 715, PAAD-HAAAD Trenton, NJ 08625 **Website:** http://www.state.nj.us/humanservices/doas/services/paad/	**Toll-free:** 1-800-792-9745 **TTY/TDD:** 711
New Jersey		
State Pharmaceutical Assistance Program	**New Jersey Senior Gold Prescription Discount Program** P.O. Box 715, PAAD-HAAAD Trenton, NJ 08625 **Website:** http://www.state.nj.us/humanservices/doas/services/seniorgold/	**Toll-free:** 1-800-792-9745 **TTY/TDD:** 711

New Mexico		
AIDS Drug Assistance Program (ADAP)	**New Mexico Department of Health – Infectious Disease Bureau: ADAP Coordinator** 1190 St. Francis Drive, Suite S1200 Santa Fe, NM 87502 **Website:** http://nmhivguide.org/search_detail.php?id=75	**Local:** 1-505-827-2435 **TTY/TDD:** 711
New Mexico		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
New Mexico		
SHIP – State Health Insurance Assistance Program	**Benefits Counseling Program** P.O. Box 27118, Santa Fe, NM 87502 **Website:** http://www.nmaging.state.nm.us/	**Toll-free:** 1-800-432-2080 **Local:** 1-505-476-4846 **TTY/TDD:** 711
New Mexico		
State Department of Insurance	**Office of Superintendent of Insurance** 1120 Paseo De Peralta, 4th Floor Santa Fe, NM 87501 **Website:** http://www.osi.state.nm.us/	**Toll-free:** 1-855-427-5674 **Local:** 1-505-827-4601 **TTY/TDD:** 711
New Mexico		
State Medical Assistance Office	**New Mexico Medicaid** P.O. Box 2348, Santa Fe, NM 87504 **Website:** http://www.hsd.state.nm.us/	**Toll-free:** 1-888-997-2583 **Local:** 1-505-827-3100 **TTY/TDD:** 711

New York		
AIDS Drug Assistance Program (ADAP)	**AIDS Institute – Department of Health – HIV Uninsured Care Programs: Director** PO Box 2052, Albany, NY 12220 **Fax:** 1-518-459-2749 **Website:** https://www.health.ny.gov/diseases/aids/general/resources/adap/	**Toll-free:** 1-800-542-2437 **Local:** 1-518-459-1641 **TTY/TDD:** 711
New York		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
New York		
SHIP – State Health Insurance Assistance Program	**Health Insurance Information Counseling and Assistance Program (HIICAP)** 162 Washington Ave Albany, NY 12210 **Fax:** 1-518-447-7188 **Website:** http://www.aging.ny.gov/HealthBenefits/Index.cfm	**Toll-free:** 1-800-701-0501 **Local:** 1-518-447-7177 **TTY/TDD:** 711
New York		
State Department of Insurance	**New York State Department of Financial Services – Consumer Assistance Unit** One Commerce Plaza, Albany, NY 12257 **Website:** http://www.dfs.ny.gov/insurance/dfs_insurance.htm	**Toll-free:** 1-800-342-3736 **Local:** 1-212-480-6400 **TTY/TDD:** 711

New York		
State Medical Assistance Office	**New York State Department of Health** Corning Tower, Empire State Plaza Albany, NY 12237 **Website:** http://www.health.ny.gov/health_care/medicaid/index.htm	**Toll-free:** 1-800-541-2831 **TTY/TDD:** 711
New York		
State Pharmaceutical Assistance Program	**New York State EPIC (Senior Pharmaceutical Insurance Coverage)** P.O. Box 15018, Albany, NY 12212 **Fax:** 1-518-452-3576 **Website:** http://www.health.ny.gov/health_care/epic/	**Toll-free:** 1-800-332-3742 **TTY/TDD:** 1-800-290-9138
North Carolina		
AIDS Drug Assistance Program (ADAP)	**North Carolina Depart of Health and Human Services – HIV/STD Prevention and Care Branch, Division of Public Health, Interim ADAP** 1902 Mail Service Center Raleigh, NC 27699 **Fax:** 1-919-715-5221 **Website:** http://epi.publichealth.nc.gov/cd/hiv/adap.html	**Toll-free:** 1-877-466-2232 In State Only **Local:** 1-919-733-9161 **TTY/TDD:** 711
North Carolina		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776

North Carolina		
SHIP – State Health Insurance Assistance Program	**Seniors Health Insurance Information Program (SHIIP)** 325 N. Salisbury Street, Albemarie Bldg Raleigh, NC 27699 **Fax:** 1-919-807-6901 **Website:** http://www.ncdoi.com/SHIIP/	**Toll-free:** 1-855-408-1212 **Local:** 1-919-807-6901 **TTY/TDD:** 711
North Carolina		
State Department of Insurance	**North Carolina Department of Insurance – Services for Consumers** 325 N. Salisbury Street, Raleigh, NC 27603 **Fax:** 1-919-733-6495 **Website:** http://www.ncdoi.com	**Toll-free:** 1-855-408-1212 **Local:** 1-919-807-6000 **TTY/TDD:** 711
North Carolina		
State Medical Assistance Office	**North Carolina Department of Health and Human Services – Medicaid** 2501 Mail Service Center, Raleigh, NC 27699 **Fax:** 1-919-733-6608 **Website:** http://dma.ncdhhs.gov/	**Toll-free:** 1-800-662-7030 **Local:** 1-919-855-4100 **TTY/TDD:** 711
North Carolina		
State Pharmaceutical Assistance Program	**North Carolina HIV SPAP** 1902 Mail Service Center Raleigh, NC 27699 **Website:** https://epi.publichealth.nc.gov/cd/hiv/hmap.html	**Toll-free:** 1-877-466-2232 In State Only **Local:** 1-919-733-7301 **TTY/TDD:** 711

North Dakota		
AIDS Drug Assistance Program (ADAP)	**North Dakota Department of Health: Prevention and ADAP Coordinator** 2635 East Main Avenue, Bismarck, ND 58506 **Fax:** 1-701-328-0356 **Website:** http://www.ndhealth.gov/HIV	**Toll-free:** 1-800-472-2180 In State Only **Local:** 1-701-328-2378 **TTY/TDD:** 1-800-366-6889
North Dakota		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
North Dakota		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Counseling (SHIC)** 600 E. Boulevard Ave., Bismarck, ND 58505 **Fax:** 1-701-328-9610 **Website:** http://www.nd.gov/ndins/shic/	**Toll-free:** 1-888-575-6611 **Local:** 1-701-328-2440 **TTY/TDD:** 1-800-366-6888
North Dakota		
State Department of Insurance	**North Dakota Insurance Department** State Capitol, fifth floor 600 E. Boulevard Ave., Bismarck, ND 58505 **Fax:** 1-701-328-4880 **Website:** http://www.state.nd.us/ndins/	**Toll-free:** 1-800-247-0560 **Local:** 1-701-328-2440 **TTY/TDD:** 1-800-366-6888
North Dakota		
State Medical Assistance Office	**North Dakota, Department of Human Services – North Dakota Medical Services** 600 E Boulevard Ave, Dept 325 Bismarck, ND 58505 **Fax:** 1-701-328-1544 **Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid/	**Toll-free:** 1-800-755-2604 **Local:** 1-701-328-7068 **TTY/TDD:** 711

Ohio		
AIDS Drug Assistance Program (ADAP)	**Ohio Department of Health – HIV Care Services – Ohio Department of Health: OHDAP Administrator** 246 N. High Street, 6th Floor Columbus, OH 43215 **Fax:** 1-866-448-6337 **Website:** http://www.odh.ohio.gov/odhPrograms/hastpac/hivcare/aids1.aspx	**Toll-free:** 1-800-777-4775 **Local:** 1-614-466-6374 **TTY/TDD:** 711
Ohio		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Ohio		
SHIP – State Health Insurance Assistance Program	**Ohio Senior Health Insurance Information Program (OSHIIP)** 50 W. Town Street, Third Floor – Suite 300 Columbus, OH 43215 **Fax:** 1-614-752-0740 **Website:** http://www.insurance.ohio.gov/Consumer/Pages/ConsumerTab2.aspx	**Toll-free:** 1-800-686-1578 **TTY/TDD:** 711
Ohio		
State Department of Insurance	**Ohio Department of Insurance** 50 W. Town Street, Third Floor – Suite 300 Columbus, OH 43215 **Fax:** 1-614-644-3744 **Website:** http://www.insurance.ohio.gov	**Toll-free:** 1-800-686-1526 **Local:** 1-614-644-2658 **TTY/TDD:** 711
Ohio		
State Medical Assistance Office	**Ohio Department of Medicaid** 50 West Town Street, Suite 400 Columbus, OH 43215 **Website:** http://medicaid.ohio.gov/	**Toll-free:** 1-800-324-8680 **TTY/TDD:** 711

Oklahoma		
AIDS Drug Assistance Program (ADAP)	**Oklahoma State Department of Health – HIV/STD Service: HDAP/ADAP Programs Manager** 1000 N.E. 10th Street, Oklahoma City, OK 73117 **Website:** http://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/	**Toll-free:** 1-800-522-0203 **Local:** 1-405-271-4636 **TTY/TDD:** 711
Oklahoma		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Oklahoma		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Counseling Program (SHIP)** 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112 **Fax:** 1-405-522-4492 **Website:** http://www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html	**Toll-free:** 1-800-763-2828 In State Only **Local:** 1-405-521-6628 **TTY/TDD:** 1-877-588-6025
Oklahoma		
State Department of Insurance	**Oklahoma Insurance Department – Consumer Service Division** Five Corporate Plaza, 3625 NW 56th St., Suite 100 Oklahoma City, OK 73112 **Fax:** 1-405-521-6635 **Website:** https://www.ok.gov/oid	**Toll-free:** 1-800-522-0071 In State Only **Local:** 1-405-521-2828 **TTY/TDD:** 711

Oklahoma		
State Medical Assistance Office	**Oklahoma Health Care Authority (SoonerCare)** 4345 N.Lincoln Blvd, Oklahoma City, OK 73105 **Website:** www.okhca.org	**Toll-free:** 1-800-987-7767 **Local:** 1-405-522-7300 **TTY/TDD:** 711
Oregon		
AIDS Drug Assistance Program (ADAP)	**Oregon Department of Human Resources – HIV/STD/TB Program: HIV Client Service Manager** 800 NE Oregon Street Suite 1105, Portland, OR 97232 **Fax:** 1-971-673-0177 **Website:** https://www.oregon.gov/DHS/pages/index.aspx	**Toll-free:** 1-800-805-2313 **Local:** 1-971-673-0144 **TTY/TDD:** 1-971-673-0372
Oregon		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6672 **Appeals Fax:** 1-855-694-2929 **Website:** http://bfccqioarea5.com	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-855-887-6668
Oregon		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Benefits Assistance (SHIBA)** P.O. Box 14480 Salem, OR 97309 **Fax:** 1-503-947-7092 **Website:** http://oregonshiba.org	**Toll-free:** 1-800-722-4134 **Local:** 1-503-947-7979 **TTY/TDD:** 1-800-735-2900

Oregon		
State Department of Insurance	**Oregon Department of Consumer and Business Services** **Division of Financial Regulation** P.O. Box 14480 Salem, OR 97309 **Fax:** 1-503-947-7092 **Website:** http://www.insurance.oregon.gov	**Toll-free:** 1-888-877-4894 **Local:** 1-503-947-7984 **TTY/TDD:** 711
Oregon		
State Medical Assistance Office	**Oregon Health Plan** 500 Summer St. NE, Salem, OR 97301 **Fax:** 1-503-378-5628 **Website:** http://www.oregon.gov/oha/healthplan/pages/index.aspx	**Toll-free:** 1-800-699-9075 **Local:** 1-503-945-5772 **TTY/TDD:** 1-503-378-6791
Pennsylvania		
AIDS Drug Assistance Program (ADAP)	**Department of Health – Division of Pharmacy Program Operations, Bureau of Fee for Service Programs: SPBP Administrator** P.O. Box 80888, Harrisburg, PA 17105 **Fax:** 1-888-656-0372 **Website:** http://www.health.pa.gov/spbp	**Toll-free:** 1-800-922-9384 **TTY/TDD:** 711
Pennsylvania		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289

Pennsylvania		
SHIP – State Health Insurance Assistance Program	**APPRISE** 555 Walnut Street, 5th Floor Harrisburg, PA 17101 **Website:** http://www.aging.pa.gov/aging-services/insurance	**Toll-free:** 1-800-783-7067 **Local:** 1-717-783-1550 **TTY/TDD:** 711
Pennsylvania		
State Department of Insurance	**Pennsylvania Insurance Department** 1326 Strawberry Square, Harrisburg, PA 17120 **Fax:** 1-717-787-8585 **Website:** http://www.insurance.pa.gov	**Toll-free:** 1-877-881-6388 **Local:** 1-717-787-2317 **TTY/TDD:** 711
Pennsylvania		
State Medical Assistance Office	**Department of Human Services** P.O. Box 2675, Harrisburg, PA 17105 **Website:** http://www.dhs.pa.gov/citizens/healthcaremedicalassistance	**Toll-free:** 1-800-692-7462 **TTY/TDD:** 711
Pennsylvania		
State Pharmaceutical Assistance Program	**Pharmaceutical Assistance Contract for the Elderly (PACE) – (PACENET)** 555 Walnut St, 5th floor Harrisburg, PA 17105 **Fax:** 1-888-656-0372 **Website:** http://www.aging.pa.gov/prescriptions	**Toll-free:** 1-800-225-7223 **Local:** 1-717-651-3600 **TTY/TDD:** 711
Rhode Island		
AIDS Drug Assistance Program (ADAP)	**Rhode Island Department Health – Office of HIV/AIDS and Viral Hepatitis: Assistant ADAP Coordinator** 3 Capitol Hill Providence, RI 02908 **Fax:** 1-401-222-1797 **Website:** http://www.health.ri.gov/diseases/hivaids/about/stayinghealthy/	**Local:** 1-401-222-5960 **TTY/TDD:** 711

Rhode Island		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-844-420-6671 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
Rhode Island		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Program (SHIP)** 74 West Road, Hazard Bldg Cranston, RI 02920 **Website:** http://www.dea.ri.gov/insurance/	**Local:** 1-401-462-0510 **TTY/TDD:** 711
Rhode Island		
State Department of Insurance	**State of Rhode Island Department of Business Regulation – Division of Insurance** 1511 Pontiac Avenue, Bldg. #69-2 Cranston, RI 02920 **Fax:** 1-401-462-9532 **Website:** http://www.dbr.state.ri.us	**Local:** 1-401-462-9500 **TTY/TDD:** 711
Rhode Island		
State Medical Assistance Office	**Rhode Island Department of Human Services** 57 Howard Avenue, Cranstion, RI 02920 **Website:** http://www.dhs.ri.gov	**Toll-free:** 1-855-697-4347 **Local:** 1-401-462-5300 **TTY/TDD:** 1-800-745-6575
Rhode Island		
State Pharmaceutical Assistance Program	**Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) – Attention RIPAE Rhode Island Department of Elderly Affairs** 25 Howard Avenue, Louis Pateur Bldg., 2nd floor Cranston, RI 02920 **Website:** http://www.dea.state.ri.us/programs/prescription_assist.php	**Local:** 1-401-462-3000 **TTY/TDD:** 1-401-462-0740

South Carolina		
AIDS Drug Assistance Program (ADAP)	**South Carolina Department of Health & Env. Control – HIV/AIDS Division: ADAP Director** 2600 Bull Street. Columbia, SC 29201 **Fax:** 1-803-898-0475 **Website:** http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/	**Toll-free:** 1-800-856-9954 **Local:** 1-803-898-3432 **TTY/TDD:** 711
South Carolina		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
South Carolina		
SHIP – State Health Insurance Assistance Program	**(I-CARE) Insurance Counseling Assistance and Referrals for Elders** 1301 Gervais Street, Suite 350 Columbia, SC 29201 **Fax:** 1-803-734-9886 **Website:** http://aging.sc.gov/	**Toll-free:** 1-800-868-9095 **Local:** 1-803-734-9900 **TTY/TDD:** 711
South Carolina		
State Department of Insurance	**South Carolina Department of Insurance** 1201 Main Street, Suite 1000 Columbia, SC 29201 **Fax:** 1-803-737-6231 **Website:** http://www.doi.sc.gov	**Toll-free:** 1-800-768-3467 **Local:** 1-803-737-6160 **TTY/TDD:** 711

South Carolina		
State Medical Assistance Office	**Healthy Connection South Carolina Medicaid Program** P. O. Box 8206, Columbia, SC 29202 **Fax:** 1-877-552-4672 **Fax Appeals:** 1-888-835-2086 **Website:** https://www.scchoices.com	**Toll-free:** 1-877-552-4642 **Local:** 1-803-898-2500 **TTY/TDD:** 1-877-552-4670
South Dakota		
AIDS Drug Assistance Program (ADAP)	**Health Department – Office of Disease Prevention; HIV Surveillance, Ryan White CARE Programs: Ryan White CARE/ADAP Program Manager** 600 East Capital Avenue, Pierre, SD 57501 **Fax:** 1-605-773-5683 **Website:** https://doh.sd.gov/diseases/infectious/ryanwhite/	**Toll-free:** 1-800-592-1861 **Local:** 1-605-773-3361 **TTY/TDD:** 711
South Dakota		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
South Dakota		
SHIP – State Health Insurance Assistance Program	**Senior Health Information & Insurance Education (SHIINE)** 2300 W 46th Street Sioux Falls, SD 57105 **Website:** http://www.shiine.net	**Toll-free:** 1-800-536-8197 **Local:** 1-605-333-3314 **TTY/TDD:** 711

South Dakota		
State Department of Insurance	**South Dakota Department of Labor and Regulation – Division of Insurance** 124 S. Euclid Ave., 2nd Floor Pierre, SD 57501 **Fax:** 1-605-773-5369 **Website:** http://dlr.sd.gov/insurance/	**Local:** 1-605-773-3563 **TTY/TDD:** 711
South Dakota		
State Medical Assistance Office	**Department of Social Services** 700 Governors Drive, Pierre, SD 57501 **Fax:** 1-605-773-5246 **Website:** http://dss.sd.gov/medicaid/	**Toll-free:** 1-800-597-1603 **Local:** 1-605-773-3495 **TTY/TDD:** 711
Tennessee		
AIDS Drug Assistance Program (ADAP)	**Tennessee Department of Health – HIV/AIDS/STD Section: Ryan White Part B Medical Services Program** 710 James Robertson Parkway, Nashville, TN 37243 **Fax:** 1-615-253-1686 **Website:** https://www.tn.gov/health/health-program-areas/std0/std/ryanwhite.html	**Toll-free:** 1-800-525-2437 **Local:** 1-615-741-7500 **TTY/TDD:** 711
Tennessee		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Tennessee		
SHIP – State Health Insurance Assistance Program	**TN SHIP** 502 Deaderick Street, 9th Floor Nashville, TN 37243 **Fax:** 1-615-741-3309 **Website:** https://www.tn.gov/aging/	**Toll-free:** 1-877-801-0044 **Local:** 1-615-741-2056 **TTY/TDD:** 711

Tennessee		
State Department of Insurance	**Tennessee Department of Commerce and Insurance – Insurance Division** 500 James Robertson Parkway, Davy Crockett Tower, 12th Floor Nashville, TN 37243 **Fax:** 1-615-532-7389 **Website:** www.tennessee.gov/commerce	**Toll-free:** 1-800-342-4029 **Local:** 1-615-741-2218 **TTY/TDD:** 711
Tennessee		
State Medical Assistance Office	**TennCare Division of Health Care and Finance** 310 Great Circle Rd., Nashville, TN 37243 **Website:** https://www.tn.gov/tenncare.html	**Toll-free:** 1-800-342-3145 **Local:** 1-855-259-0701 **TTY/TDD:** 711
Texas		
AIDS Drug Assistance Program (ADAP)	**Texas Department of State Health Services – Department of State Health Services** **Attn: MSJA** P.O. Box 149347, MC 1873, Austin, TX 78714 **Fax:** 1-512-533-3178 **Website:** https://www.dshs.texas.gov/hivstd/meds/	**Toll-free:** 1-800-255-1090 **Local:** 1-512-533-3000 **TTY/TDD:** 1-800-735-2989
Texas		
SHIP – State Health Insurance Assistance Program	**Dept. of Aging and Disability Services / Health Information Counseling and Advocacy Program (HICAP)** 701 W. 51st St., Austin, TX 78751 **Fax:** 1-512-475-1771 **Website:** http://www.tdi.texas.gov/consumer/hicap/	**Toll-free:** 1-800-252-9240 **TTY/TDD:** 711

Texas		
State Department of Insurance	**Texas Department of Insurance** P.O. Box 149104, Austin, TX 78714 **Fax:** 1-512-490-1045 **Website:** http://www.tdi.texas.gov/	**Toll-free:** 1-800-578-4677 **Local:** 1-512-676-6000 **TTY/TDD:** 711
Texas		
State Medical Assistance Office	**Texas Health and Human Services Commission** PO BOX 149024, Austin, TX 78714 **Website:** https://hhs.texas.gov/	**Toll-free:** 1-877-541-7905 **Local:** 1-512-424-6500 **TTY/TDD:** 711
Texas		
State Pharmaceutical Assistance Program	**Texas Kidney Health Care Program** Department of State Health Services, MC 1938,, PO Box 149347 Austin, TX 78714 **Fax:** 1-512-776-7162 **Website:** https://www.dshs.state.tx.us kidney/default.shtm	**Toll-free:** 1-800-222-3986 **Local:** 1-512-776-7150 **TTY/TDD:** 711
Utah		
AIDS Drug Assistance Program (ADAP)	**Utah Department of Health – Bureau of Communicable Disease Control, Treatment and Care Services Program: ADAP Coordinator** Cannon Health Building, 288 North 1460 West, Salt Lake City, UT 84116 **Fax:** 1-801-536-0978 **Website:** http://health.utah.gov/epi/treatment/	**Toll-free:** 1-888-222-2542 **Local:** 1-801-538-6003 **TTY/TDD:** 711

Utah		
Quality Improvement Organization	**KEPRO** 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 **Fax:** 1-844-878-7921 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-430-9504 **Local:** 1-216-447-9604 **TTY/TDD:** 1-855-843-4776
Utah		
SHIP – State Health Insurance Assistance Program	**Senior Health Insurance Information Program (SHIP)** 195 North 1950 West, Salt Lake City, UT 84116 **Fax:** 1-801-538-4395 **Website:** https://daas.utah.gov/seniors/	**Toll-free:** 1- 800-541-7735 **Local:** 1-801-538-3910 **TTY/TDD:** 711
Utah		
State Department of Insurance	**Utah Insurance Department** State Office Building Rm 3110 350 N. State St. Salt Lake City, UT 84114 **Fax:** 1-801-538-3829 **Website:** http://www.insurance.utah.gov	**Toll-free:** 1-800-439-3805 **Local:** 1-801-538-3800 **TTY/TDD:** 711
Utah		
State Medical Assistance Office	**Utah Department of Health Medicaid** P.O. Box 143106, Salt Lake City, UT 84114 **Fax:** 1-801-538-6805 **Website:** http://health.utah.gov/medicaid/	**Toll-free:** 1-800-662-9651 **Local:** 1-801-538-6155 **TTY/TDD:** 711
Vermont		
AIDS Drug Assistance Program (ADAP)	**Vermont Dept. of Health: ADAP Cooridinator** 108 Cherry Street Burlington, VT 05402 **Fax:** 1-802-865-7754 **Website:** http://healthvermont.gov/prevent/aids/aids_index.aspx	**Toll-free:** 1-800-464-4343 **Local:** 1-802-863-7200 **TTY/TDD:** 711

Vermont		
Quality Improvement Organization	**Livanta** 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701- 1105 **Fax:** 1-844-420-6671 **Appeals Fax:** 1-855-236-2423 **Website:** http://bfccqioarea1.com/	**Toll-free:** 1-866-815-5440 **TTY/TDD:** 1-866-868-2289
Vermont		
SHIP – State Health Insurance Assistance Program	**State Health Insurance Assistance Program (SHIP)** HC 2 South, 280 State Drive Waterbury, VT 05671-2070 **Fax:** 1-802-241-0385 **Website:** http://www.cvaa.org/ship.html	**Toll-free:** 1-800-642-5119 **Local:** 1-802-241-0294 **TTY/TDD:** 711
Vermont		
State Department of Insurance	**Vermont Department of Financial Regulation – Insurance Division** 89 Main Street, Montpelier, VT 05620 **Fax:** 1-802-828-3306 **Website:** http://www.dfr.vermont.gov/insurance/insurance-division	**Toll-free:** 1-800-964-1784 **Local:** 1-802-828-3301 **TTY/TDD:** 711
Vermont		
State Medical Assistance Office	**Green Mountain Care** 280 State Drive Waterbury, VT 05671 **Website:** http://greenmountaincare.org	**Toll-free:** 1-800-250-8427 **TTY/TDD:** 711
Vermont		
State Pharmaceutical Assistance Program	**Vermont Health Access Plan (VHAP – Pharmacy),VSCRIPT, and VSCRIPT Expanded** 280 State Drive Waterbury, VT 05671 **Website:** http://dcf.vermont.gov/benefits/prescription	**Toll-free:** 1-800-250-8427 **TTY/TDD:** 711

Virginia		
AIDS Drug Assistance Program (ADAP)	**Virginia Department of Health – HIV Care Services, Division of Disease Prevention: ADAP** 109 Governor Street, HCS Unit, 1st Floor Richmond, VA 23219 **Fax:** 1-804-864-8050 **Website:** http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/	**Toll-free:** 1-855-362-0658 **Local:** 1-804-864-8145 **TTY/TDD:** 711
Virginia		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Virginia		
SHIP – State Health Insurance Assistance Program	**Virginia Insurance Counseling and Assistance Program (VICAP)** 1610 Forest Avenue, Suite 100 Henrico, VA 23229 **Fax:** 1-804-662-9354 **Website:** http://www.vda.virginia.gov	**Toll-free:** 1-800-552-3402 **Local:** 1-804-662-9333 **TTY/TDD:** 711
Virginia		
State Department of Insurance	**Virginia State Corporation Commission – Bureau of Insurance** P.O. Box 1157, Richmond, VA 23218 **Website:** http://www.scc.virginia.gov/boi/index.aspx	**Toll-free:** 1-800-552-7945 In State Only **Local:** 1-804-371-9741 **TTY/TDD:** 711

Virginia		
State Medical Assistance Office	**Department of Medical Assistance Services** 600 East Broad Street, Richmond, VA 23219 **Website:** http://dmasva.dmas.virginia.gov/default.aspx	**Toll-free:** 1-800-643-2273 **Local:** 1-804-786-7933 **TTY/TDD:** 1-800-343-0634
Virginia		
State Pharmaceutical Assistance Program	**Virginia Division for the Aging** 1610 Forest Avenue, Henrico, VA 23229 **Fax:** 1-804-662-9354 **Website:** http://www.vda.virginia.gov/prescripassist1.asp	**Toll-free:** 1-800-552-3402 **Local:** 1-804-662-9333 **TTY/TDD:** 711
Washington		
AIDS Drug Assistance Program (ADAP)	**Washington State Health Department – HIV Client** P.O. Box 47841, Olympia, WA 98504 **Fax:** 1-360-664-2216 **Website:** http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP	**Toll-free:** 1-877-376-9316 **Local:** 1-360-236-3426 **TTY/TDD:** 711
Washington		
SHIP – State Health Insurance Assistance Program	**Statewide Health Insurance Benefits Advisors (SHIBA)** P.O. Box 40256, Olympia, WA 98504 **Website:** https://www.insurance.wa.gov/shiba	**Toll-free:** 1-800-562-6900 **TTY/TDD:** 711

Washington		
State Department of Insurance	**Washington State Office of the Insurance Commissioner** P.O. Box 40255, Olympia, WA 98504 **Website:** http://www.insurance.wa.gov/	**Toll-free:** 1-800-562-6900 **Local:** 1-360-725-7000 **TTY/TDD:** 1-800-208-2620
Washington		
State Medical Assistance Office	**Washington State Health Care Authority** P.O. Box 11699, Tacoma, WA 98411 **Website:** http://www.hca.wa.gov/medicaid/Pages/index.aspx	**Toll-free:** 1-800-562-3022 **TTY/TDD:** 1-800-848-5429
Washington		
State Pharmaceutical Assistance Program	**Washington State Health Insurance Pool** PO Box 1090, Great Bend, KS 67530 **Fax:** 1-620-793-1199 **Website:** https://www.wship.org/	**Toll-free:** 1-800-877-5187 **TTY/TDD:** 711
West Virginia		
AIDS Drug Assistance Program (ADAP)	**West Virginia Department of Health & Social Services – Division of Surveillance and Disease Control: HIV Care Coordinator** 40 12th Street, Wheeling, WV 26003 **Fax:** 1-740-695-3252 **Website:** http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx	**Toll-free:** 1-800-434-9443 In State Only **Local:** 1-304-232-6822 **TTY/TDD:** 711

West Virginia		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7129 **Website:** http://www.keproqio.com	**Toll-free:** 1-844-455-8708 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
West Virginia		
SHIP – State Health Insurance Assistance Program	**West Virginia State Health Insurance Assistance Program (WV SHIP)** 1900 Kanawha Blvd. East, Charleston, WV 25305 **Fax:** 1-304-558-0004 **Website:** http://www.wvship.org	**Toll-free:** 1-877-987-4463 **Local:** 1-304-558-3317 **TTY/TDD:** 711
West Virginia		
State Department of Insurance	**West Virginia Offices of the Insurance Commissioner** PO Box 50540, Charleston, WV 25305 **Fax:** 1-304-558-4965 **Website:** http://www.wvinsurance.gov	**Toll-free:** 1-888-879-9842 **Local:** 1-304-558-3386 **TTY/TDD:** 711
West Virginia		
State Medical Assistance Office	**West Virginia Bureau for Medical Services** 350 Capitol Street, Room 251 Charleston, WV 25301 **Website:** http://www.dhhr.wv.gov/bms/	**Toll-free:** 1-800-642-8589 **Local:** 1-304-558-1700 **TTY/TDD:** 711
Wisconsin		
AIDS Drug Assistance Program (ADAP)	**Wisconsin Department of Health & Family Services: ADAP Coordinator** P.O. Box 2659 Madison, WI 53701 **Fax:** 1-608-266-1288 **Website:** https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	**Toll-free:** 1-800-991-5532 **Local:** 1-608-267-6875 **TTY/TDD:** 711

Wisconsin		
Quality Improvement Organization	**KEPRO** 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 **Fax:** 1-844-834-7130 **Website:** http://www.keproqio.com	**Toll-free:** 1-855-408-8557 **Local:** 1-813-280-8256 **TTY/TDD:** 1-855-843-4776
Wisconsin		
SHIP – State Health Insurance Assistance Program	**Wisconsin SHIP** 1402 Pankratz Street,Suite 111 Madison, WI 53704 **Fax:** 1-608-246-7001 **Website:** https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	**Toll-free:** 1-800-242-1060 **TTY/TDD:** 711
Wisconsin		
State Department of Insurance	**Wisconsin Office of the Commissioner of Insurance** 125 South Webster Street, Madison, WI 53703 **Website:** https://oci.wi.gov/pages/homepage.aspx	**Toll-free:** 1-800-236-8517 **Local:** 1-608-266-3585 **TTY/TDD:** 1-608-266-3586
Wisconsin		
State Medical Assistance Office	**Wisconsin Department of Health** 1 West Wilson Street, Madison, WI 53703 **Fax:** 1-888-409-1979 **Website:** https://www.dhs.wisconsin.gov/medicaid	**Toll-free:** 1-800-362-3002 **Local:** 1-608-266-1865 **TTY/TDD:** 711
Wisconsin		
State Pharmaceutical Assistance Program	**Wisconsin SeniorCare** P.O. Box 6710, Madison, WI 53716 **Website:** http://www.dhs.wisconsin.gov/seniorcare/	**Toll-free:** 1-800-657-2038 **TTY/TDD:** 711

Wyoming		
AIDS Drug Assistance Program (ADAP)	**Wyoming Department of Health – Communicable Disease Unit** 6101 Yellowstone Rd, Suite 510 Cheyenne, WY 82002 **Fax:** 1-307-777-7382 **Website:** http://health.wyo.gov/publichealth/communicable-disease-unit/	**Local:** 1-307-777-7529 **TTY/TDD:** 711
Wyoming		
SHIP – State Health Insurance Assistance Program	**Wyoming State Health Insurance Information Program (WSHIIP)** PO Box BD, Riverton, WY 82501 **Fax:** 1-307-856-4466 **Website:** http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	**Toll-free:** 1-800-856-4398 **Local:** 1-307-856-6880 **TTY/TDD:** 711
Wyoming		
State Department of Insurance	**Wyoming Insurance Department** 106 East 6th Avenue, Cheyenne, WY 82002 **Fax:** 1-307-777-2446 **Website:** http://insurance.state.wy.us/	**Local:** 1-307-777-7401 **TTY/TDD:** 711
Wyoming		
State Medical Assistance Office	**Wyoming Medicaid** 6101 Yellowstone Rd, Ste. 259-D Cheyenne, WY 82002 **Fax:** 1-855-329-5205 **Website:** www.health.wyo.gov	**Toll-free:** 1-855-294-2127 **Local:** 1-307-777-7656 **TTY/TDD:** 1-855-889-4325

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Aetna Medicare Rx (PDP) Customer Service

Method	Customer Service – Contact Information
CALL	Please call the telephone number printed on the back of your member ID card or our general customer service center at 1-844-233-1939. Calls to this number are free. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.
WRITE	Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088
WEBSITE	http://www.AetnaRetireePlans.com

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is on Addendum A of this *Evidence of Coverage*.

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