January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits (PSHB) Members

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

For questions about this document, please contact Member Services at 1-800-805-2739. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

This plan, Kaiser Permanente Medicare Part D Group Plan, is offered by Kaiser Permanente Insurance Company (Health Plan). (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Medicare Part D Group Plan.)

This document is available in braille, large print, audio file, or data CD if you need it by calling Member Services.

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

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

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

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

2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Kaiser Permanente Medicare Part D Group Plan, which is a Medicare Prescription Drug Plan

You are covered by Original Medicare or another health plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, Kaiser Permanente Medicare Part D Group Plan.

Kaiser Permanente Medicare Part D Group Plan is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

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

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

This *Evidence of Coverage* describes two Medicare Part D plans for postal members:

- High Option
- Standard Option

If you are not certain which plan you are enrolled in, please call Member Services or for new members, refer to your enrollment form or enrollment confirmation letter.

In order to receive the benefits described in this booklet, you must be enrolled in Kaiser Permanente through the Postal Service Health Benefits (PSHB) Program and meet the eligibility requirements described in your PSHB brochure (RI 73-920). As a member of Kaiser Permanente Medicare Part D Group Plan for PSHB, you are entitled to coverage under the PSHB Program. For a complete statement of your PSHB benefits, including any limitations and exclusions, please refer to your PSHB brochure (RI 73-920). All PSHB benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB brochure.

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

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

If you are confused, concerned or just have a question, please contact Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment form, our *2025 Group Medicare Part D Group Plan (PDP) Comprehensive 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 PSHB Program renews on January 1, and this *Evidence of Coverage* is in effect for the months in which you are enrolled in Kaiser Permanente Medicare Part D Group Plan for postal members between January 1, 2025, and December 31, 2025, unless amended.

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, 2025. We can also choose to stop offering the plan in your service area, after December 31, 2025. In addition, the PSHB Program can make changes to the plans and benefits it offers at any time.

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

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

Section 2.1 Your eligibility requirements

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

- You are enrolled in Kaiser Permanente through the PSHB Program and meet the eligibility requirements described in your PSHB brochure (RI 73-920)
- You have Medicare Part A or Medicare Part B only (or you have both Part A and Part B)
- You are not enrolled in a Medicare Advantage Plan
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area) Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is our plan service area for our Kaiser Permanente Medicare Part D Group Plan

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 our service area, which includes all of the United

States except California, Colorado, Washington, Oregon, Georgia, Virginia, Maryland, Delaware, and the District of Columbia.

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

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

Section 2.3 U.S. Citizen or Lawful Presence

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

Section 2.4 When you can enroll in this Medicare Part D Group plan and when coverage begins

You can enroll at any time. After we receive your completed Medicare Part D Election/Enrollment Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Medicare Part D coverage under this *Evidence of Coverage*.

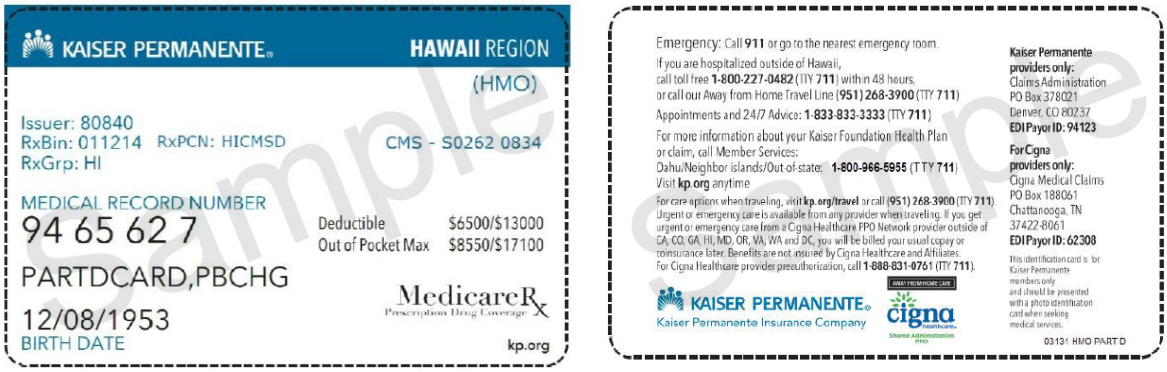
If the Centers for Medicare & Medicaid Services confirms your Medicare Part D enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from our Medicare Part D plan.

Note: If you are a subscriber under this *Evidence of Coverage* and you have dependents who do not have Medicare Part B coverage, or for some other reason are not eligible to enroll under this *Evidence of Coverage*, you may be able to enroll them as your dependents under coverage offered through the PSHB Program.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



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

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

Section 3.2 Pharmacy Directory

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

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services. You can also find this information on our website at **kp.org/directory**.

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

Our plan has a *2025 Medicare Part D Group Plan (PDP) Comprehensive Formulary*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in 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.

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

We will provide you a copy of our Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (**kp.org/seniorrx**) or call Member Services.

SECTION 4 Your costs for our plan

Your costs may include the following:

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

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" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your plan premium.

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

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

Section 4.1 Plan Premium

To receive the benefits for this Medicare Part D plan, you must continue to pay your regular PSHB Program contributions (described in the PSHB brochure RI 73-920). There is no increase in your PSHB Program contributions for Medicare Part D membership. You do not pay a separate monthly plan premium for Medicare Part D unless you are subject to the Part D late enrollment penalty. You must continue to pay Medicare premium(s) described in Section 4.2 of this chapter.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying your PSHB contribution amount (shown on the back cover of your PSHB brochure RI 73-920), **you must continue paying your Medicare premiums to remain a**

member of this plan. This includes your premium for Part B, if applicable. It may also include a premium for Part A, which affects members who aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

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

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty.

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

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

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount is $36.78.

- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $36.78, which equals $5.14. This rounds to $5.10. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

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

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

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

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

SECTION 5 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Member Services.

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

SECTION 6 How other insurance works with our plan

Other insurance

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

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

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

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

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

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

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

- Workers' compensation

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Kaiser Permanente Medicare Part D Group Plan contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Kaiser Permanente Medicare Part D Group Plan Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-800-805-2739 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 711 Kapiolani Blvd. Honolulu, HI 96813
WEBSITE	kp.org

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

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

Method	Coverage Decisions for Part D prescription drugs – Contact Information
CALL	1-888-277-3917 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

Method	Coverage Decisions for Part D prescription drugs – Contact Information
FAX	1-844-403-1028
WRITE	OptumRx c/o Prior Authorization P.O. Box 2975 Mission, KS 66201
WEBSITE	**kp.org**

Method	Appeals for Part D prescription drugs – Contact Information
CALL	1-866-233-2851 or 1-808-432-7503 Calls to these numbers are free. Seven days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.
FAX	1-808-432-5260
WRITE	Kaiser Permanente Attn: Member Relations 711 Kapiolani Blvd. Honolulu, HI 96813 Email address: KPHawaii.appeals@kp.org
WEBSITE	**kp.org**

How to contact us when you are making a complaint

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

Method	Complaints – Contact Information
CALL	1-800-805-2739 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

Method	Complaints – Contact Information
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	1-808-432-5260
WRITE	Kaiser Permanente Attn: Member Relations 711 Kapiolani Blvd. Honolulu, HI 96813
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**.

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

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

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

Method	Payment Requests – Contact Information
CALL	1-877-875-3805 Calls to this number are free. Monday through Friday, 8 a.m. to 5 p.m.
TTY	711 Calls to this number are free. Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Kaiser Permanente Claims Department Hawaii Region P.O. Box 378021 Denver, CO 80237
WEBSITE	**kp.org**

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to *Appendix A* at the back of this document for SHIP information.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Please refer to *Appendix A* at the back of the document for state QIO information.

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

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

SECTION 5 Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your

income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

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

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and its programs, contact Medicaid. Please refer to *Appendix A* at the back of the document for state Medicaid information.

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

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

Medicare's "Extra Help" Program

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

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay 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 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your state Medicaid office (See Section 6 of this chapter for contact information).

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

- If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for "Extra Help." The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.
- You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy.
- Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to:

  Kaiser Permanente
  Medicare Department
  Attn: Best Available Evidence
  P.O. Box 232400
  San Diego, CA 92193-2400
  Fax it to 1-877-528-8579

- Take it to a network pharmacy.

- 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 the payment directly to the state. Please contact Member Services if you have questions.

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

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

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the ADAP in your state.

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

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members. Please refer to *Appendix A* at the back of the document for SPAP information.

The Medicare Prescription Payment Plan

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

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	1-800-805-2739 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 711 Kapiolani Blvd. Honolulu, HI 96813
WEBSITE	**kp.org**

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

SECTION 9 Group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) have any questions about this plan, you may call the employer/union benefits administrator. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period.

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

CHAPTER 3:
Using our plan's coverage for Part D prescription drugs

SECTION 1 Introduction

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

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

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

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

We cover some drugs that are not covered by Medicare Part B or Part D in accord with our formulary for non-Part D drugs (refer to your PSHB brochure RI 73-920).

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter. *Or you can fill your prescription through the plan's mail-order service*.)
- Your drug must be on the plan's *2025 Medicare Part D Group Plan (PDP) Comprehensive Formulary* (we call it the Drug List for short). (See Section 3 in this chapter.)
- Your drug must be used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 of this chapter for more information about restrictions on your coverage.)

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

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at our 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 our plan to provide your covered prescription drugs. The term *covered drugs* means all of the Part D prescription drugs that are on our plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Medicare Part D Group Plan (PDP) Pharmacy Directory*, visit our website (**kp.org/directory**), and/or call Member Services.

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Services or use the *Medicare Part D Group Plan (PDP) Pharmacy Directory*. You can also find information on our website at **kp.org/directory**.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- 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.

To locate a specialized pharmacy, look in your *Medicare Part D Group Plan (PDP) Pharmacy Directory* (**kp.org/directory**) or call Member Services.

Section 2.3 Using our plan's mail-order service

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

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

visit your local Kaiser Permanente pharmacy or call our mail-order pharmacy at 1-808-643-7979 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call our Mail-order Pharmacy at 1-808-643-7979 (TTY 711).

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular USPS mail delivery). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed or see our Drug List for information about the drugs that can be mailed.

Usually a mail-order pharmacy order will be delivered to you in no more than 5 days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your Pharmacy Directory or at **kp.org/directory**. Please be aware that you may pay more if you get a 90-day supply from a network retail pharmacy instead of from our mail-order pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

> **Refills on mail-order prescriptions.** For refills, please contact your pharmacy 5 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Medicare Part D Group Plan (PDP) Pharmacy Directory* (**kp.org/directory**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

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

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

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered 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. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.

- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

How do you ask for reimbursement from our plan?

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

SECTION 3 Your drugs need to be on our Drug List

Section 3.1 Our Drug List tells which Part D drugs are covered

Our plan has a *2025 Medicare Part D Group Plan (PDP) Comprehensive Formulary.* In this *Evidence of Coverage*, **we call it the Drug List for short.**

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

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

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

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

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

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar

alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

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

What is *not* on our Drug List?

Our 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. In some cases, you may be able to obtain a drug that is not on our Drug List. (For more information, please see Chapter 7.)

Section 3.2 There are six cost-sharing tiers for drugs on our Drug List

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

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up in our Drug List.

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

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

You have four ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit our plan's website (**kp.org/seniorrx**). Our Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on our plan's Drug List (*2025 Medicare Part D Group Plan (PDP) Formulary Comprehensive Formulary*) or to ask for a copy of the list.
4. Use our plan's "Real-Time Benefit Tool" (**kp.org/seniorrx**) or by calling Member Services). With this tool you can search for drugs on the Drug List to see an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

Section 4.2 What kinds of restrictions?

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

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

Getting plan approval in advance

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

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

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

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

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

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

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

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

You may be able to get a temporary supply

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

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

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

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For current members with level of care changes:** If you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may require an additional fill of your medication. We will generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our Drug List.

For questions about a temporary supply, call Member Services.

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

1) You can change to another drug

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

2) You can ask for an exception

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

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

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

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

You can change to another drug

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

You can ask for an exception

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

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

Drugs in our specialty tier (Tier 5) are not eligible for this type of exception. We do not lower the cost sharing amount for drugs in this tier.

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

Section 6.1 The Drug List can change during the year

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

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

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

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

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

Information on changes to drug coverage

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

Changes we may make to the Drug List that affect you during the current plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to our Drug List, we may immediately remove a like drug from our Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We will make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on our Drug List.
    - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the

like drug at the time we make the change, we will tell you about any specific change we made.

- **Adding drugs to our Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
    - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 7.

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

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

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other changes noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

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

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

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 (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

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

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

In addition, by law, the following categories of drugs are not covered by Medicare drug plans (Our plan covers certain drugs listed below through our enhanced drug coverage. More information is provided below.):

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

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

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Please refer to your PSHB Brochure (RI 73-920) for more information. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 6 of this document.)

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

Check your *Medicare Part D Group Plan (PDP) Pharmacy Directory* (**kp.org/directory**) to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you are taking 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 getting other drug coverage from an employer or retiree group plan?

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

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

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

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or

anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide

your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

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

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

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

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

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

CHAPTER 4:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs are covered under your PSHB plan (refer to your PSHB brochure RI 73-920).

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time," meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Member Services.

This *Evidence of Coverage* describes two Medicare Part D plans for postal members:

- High Option
- Standard Option

If you are not certain which plan you are enrolled in, please call Member Services or for new members, refer to your enrollment form or enrollment confirmation letter.

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

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

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

- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

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

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

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

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

- The amount you pay for drugs when you are in 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* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

- Your PSHB contribution amount.
- 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 that are not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs that are made by the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

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

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

- We will help you. The *Part D Explanation of Benefits* (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $2,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 2.1 What are the drug payment stages for Kaiser Permanente Medicare Part D Group Plan?

There are three **drug payment stages** for your prescription drug coverage under our plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

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

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

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

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs.** This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.

- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. You can also choose to view your Part D EOB online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your Part D EOB securely online. Be sure to keep these reports.

SECTION 4 There is no deductible for our plan

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, we pay our 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, we pay our 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.

Our plan has six cost-sharing tiers

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

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs. You pay $35 per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 4** for nonpreferred drugs (this tier includes both generic and brand-name drugs). You pay $35 per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs). You pay $35 per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up in our 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.
- A pharmacy that is not in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 and our plan's *Medicare Part D Group Plan (PDP) Pharmacy Directory* (**kp.org/directory**).

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

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

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

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

Tier	**Retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
Tier 1 – Preferred generic drugs (all plans)	**$5**	**$0**	**$5**	**$5**
Tier 2 – Generic drugs • High Option	**$10**			
• Standard Option	**$15**			
Tier 3 – Preferred brand-name drugs* (all plans) **Tier 4 – Nonpreferred drugs*** (all plans)	**$45**			
Tier 5 – Specialty-tier drugs* (all plans)	**$200**			
Tier 6 – Injectable Part D vaccines (all plans)	**$0**	Mail-order isn't available.	**$0**	

*You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 7 of this chapter for more information on cost sharing for Part D vaccines.

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

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

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

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

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

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

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

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

Tier	Retail cost sharing (in-network) (31–60 day supply)	Retail cost sharing (in-network) (61–90 day supply)	Mail-order cost sharing (31–90 day supply)
Tier 1 – Preferred generic drugs (all plans)	**$10**	**$15**	**$0**
Tier 2 – Generic drugs			
• High Option	**$20**	**$30**	**$20**

Tier	Retail cost sharing (in-network) (31–60 day supply)	Retail cost sharing (in-network) (61–90 day supply)	Mail-order cost sharing (31–90 day supply)
• Standard Option	**$30**	**$45**	**$30**
Tier 3 – Preferred brand-name drugs* (all plans) **Tier 4 – Nonpreferred drugs*** (all plans)	**$90**	**$135**	**$90**
Tier 5 – Specialty-tier drugs* (all plans)	**$400**	**$600**	**$400**
Tier 6 – Injectable Part D vaccines (all plans)	**A long-term supply isn't available.**		

*For each covered insulin product in Tiers 3-5, you won't pay more than **$70** for up to a two-month supply or **$105** for up to a three-month supply.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,000**. You then move on to the Catastrophic Coverage Stage.

We 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 toward your total out-of-pocket costs.

The *Part D EOB* that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,000 out-of-pocket limit in a year.

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

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the 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 payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's Drug List or contact Member Services for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

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

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

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccinations are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

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

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

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan

to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.

- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

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

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

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

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

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

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid.

IMPORTANT NOTE: There is no charge for covered Part D vaccines and their administration. However, there may be an office visit charge if administered during a provider office visit.

CHAPTER 5:
Asking us to pay our share of the costs for covered drugs

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

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

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 our plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

- For example, the drug may not be on our plan’s Drug List or it could have a requirement or restriction that you didn’t know about or don’t think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you are retroactively enrolled in our plan

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

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

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

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 36 months (for Part D drug claims)** of the date you received the service, item, or drug.

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. You can file a claim to request payment by:

- Completing and submitting our electronic form at **kp.org** and upload supporting documentation.
- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
  - ♦ A statement with the following information:
  - o Your name (member/patient name) and medical/health record number.
  - o The date you received the services.
  - o Where you received the services.
  - o Who provided the services.
  - o Why you think we should pay for the services.

- Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed "Appointment of Representative" form, which is available at **kp.org**.)

- A copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services.

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

Kaiser Permanente
Claims Department
Hawaii Region
P.O. Box 378021
Denver, CO 80237

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

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

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

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). We will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, audio file, or data CD)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

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

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 Member Services. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practices*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

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

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

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services.

- **Information about our plan.** This includes, for example, information about the plan's financial condition.

- **Information about our network pharmacies.** You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the state agency that oversees advance directives. To locate the agency in your state, contact your SHIP. Please refer to Appendix A at the back of the document for SHIP information.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly**.

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

Section 1.9 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

Section 1.10 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions.

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

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services.

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

CHAPTER 7:

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

SECTION 1 Introduction

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

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

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

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

Other dispute resolution options

As a PSHB member, you also have additional dispute resolution rights and a different appeals process through the PSHB Program. For a complete statement of your drug benefits and rights under the PSHB Program, please read your PSHB brochure (RI 73-920). All PSHB Program benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB brochure.

Note: If you have an issue relating to coverage of a drug that is not covered by Medicare, but is covered under your PSHB membership, please refer to your PSHB brochure for dispute resolution options because the Medicare appeal process does not apply.

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Please refer to *Appendix A* at the back of the document for SHIP information.

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

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

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

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

will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or *fast appeal* of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Part D appeals are discussed further in Section 5 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or another person to be your representative, call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *2025 Medicare Part D Group Plan (PDP) Comprehensive Formulary*.
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 5.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first) **Ask for an exception. Section 5.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

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

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

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

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

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for nonpreferred drugs or Tier 2 for generic drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
    - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You cannot ask us to change the cost-sharing tier for any drug in Tier 5.
    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called *alternative* drugs. If an alternative drug would be just as

effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

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

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

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

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

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

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.

- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website (**kp.org**). Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the *supporting statement*,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

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

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

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

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

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

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A *fast appeal* is also called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

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

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (**kp.org**). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.

  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.

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

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

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

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

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

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

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

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

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

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

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

bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

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

For standard appeals:

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

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called *upholding the decision*. It is also called *turning down your appeal*.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

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

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

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

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

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your

request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.

  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

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

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

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

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our Medicare Part D Group 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. Sections 2 and 3 provide information on ending your membership voluntarily.
    - You can disenroll from Medicare Part B or this Medicare Part D plan at any time, however, you should first review your PSHB brochure (RI 73-920) before you disenroll.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your Medicare Part D Group plan membership.

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

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

You may terminate (disenroll from) your Medicare Part D Group plan membership at any time.

If you request disenrollment, your disenrollment effective date will be the first day of the month following our receipt of your written, signed, and dated disenrollment request.

When your Medicare Part D Group plan coverage ends, you may continue your PSHB membership if you still meet the requirements for PSHB coverage. However, your drug benefits and cost sharing are not the same and are described in the PSHB brochure (RI 73-920).

Other Medicare plans

If you want to enroll in another Medicare health plan or a Medicare prescription drug plan, you should first confirm with the other plan and the PSHB Program that you are able to enroll. Your new plan or the PSHB Program will tell you the date when your membership in the new plan begins and your Medicare Part D group plan membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare health plan, so you will not need to send us a disenrollment request.

Original Medicare

If you receive "Extra Help" from Medicare to pay for your prescription drugs, and you switch to Original Medicare and do not enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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

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.

Section 2.3 Where can you get more information about when you can end your Medicare Part D Group plan membership?

If you have any questions about ending your Medicare Part D Group plan membership you can:

- Contact your PSHB Program benefits administrator. You should always consult them before taking any action because it can affect your eligibility for PSHB Program benefits.
- **Call Member Services**.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our Medicare Part D Group plan?

You may request disenrollment by:

- Requesting disenrollment with **the PSHB Program's** benefits administrator.
- Calling toll free 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- Sending written notice to the following address:

  Kaiser Permanente
  Medicare Department
  P.O. Box 232400
  San Diego, CA 92193-2400

SECTION 4 Until your membership ends, you must keep getting your drugs through our Medicare Part D Group plan

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

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

SECTION 5 We must end your membership in our Medicare Part D Group plan in certain situations

Section 5.1 When must we end your membership in our Medicare Part D Group 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, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Member Services.

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

We are not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

Section 5.4 What happens if you are no longer eligible for PSHB coverage?

After your group notifies us to terminate your group membership, we will send a termination letter to the subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

- If you are no longer eligible for PSHB membership, you can request enrollment in our Kaiser Permanente Senior Advantage Individual Plan if you meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this *Evidence of Coverage* and will include Medicare Part D prescription drug coverage.

- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5.1. For more information or information about other individual plans, call Member Services.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Medicare Part D Group Plan, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Evidence of Coverage*.

SECTION 5 Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Evidence of Coverage*.

SECTION 6 Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 7 Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses, except as otherwise required by law.

SECTION 8 Coordination of benefits

As described in Chapter 1, Section 7, "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Kaiser Permanente Medicare Part D Group Plan member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 16 in this chapter, and for primary payments in workers' compensation cases, see Section 18 in this chapter.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

SECTION 9 Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

SECTION 10 *Evidence of Coverage* binding on members

By electing coverage or accepting benefits under this *Evidence of Coverage*, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this *Evidence of Coverage*.

SECTION 11 Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 12 Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

SECTION 13 No waiver

Our failure to enforce any provision of this *Evidence of Coverage* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

SECTION 14 Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this document) and Social Security at 1-800-772-1213 (TTY 1-800-325-0778) as soon as possible to report your address change.

SECTION 15 Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

SECTION 16 Third party liability

As stated in Chapter 1, Section 7, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

Note: This "Third party liability" section does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Kaiser Permanente
Patient Financial Services Department
Insurance Follow-up Manager
711 Kapiolani Blvd.
Honolulu, HI 96813

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment

recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

SECTION 17 U.S. Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

SECTION 18 Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 7, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

SECTION 19 Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

SECTION 20 Binding arbitration

Except as provided in this chapter or by applicable law, any and all claims, disputes, or causes of action arising out of or related to this *Evidence of Coverage*, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

By enrolling in Kaiser Permanente Medicare Part D Group Plan, you waive all rights to have these types of claims decided in a court of law. The arbitrator's decision is binding.

This includes but is not limited to any claim asserted:

1. By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this *Evidence of Coverage*, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;
2. On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this *Evidence of Coverage*, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
3. By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
    - Health Plan
    - Kaiser Foundation Health Plan, Inc.,
    - Kaiser Foundation Hospitals,
    - Hawaii Permanente Medical Group, Inc.,
    - The Permanente Federation, LLC.
    - Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this *Evidence of Coverage*, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under this *Evidence of Coverage* (such as temporary restraining orders, and emergency court orders);
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Initiating arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation), and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable

opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this *Evidence of Coverage* or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

General provisions

All claims based upon the same incident, transaction or related circumstances regarding the same member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this *Evidence of Coverage* in any particular case, then such term(s) shall be severable in that case and the remainder of this *Evidence of Coverage* shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this *Evidence of Coverage* shall supersede those in any prior *Evidence of Coverage*.

Arbitration confidentiality

This *Evidence of Coverage* concerns personal medical information whose confidentiality is protected by law. Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special claims

Medical Malpractice Claims:

Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11–19. Following the rendering of an advisory decision by the

Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the "Initial arbitration" section.

Benefit Claims:

If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at 1-800-966-5955. Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initial arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to this Section 20 and Chapter 7.

External Appeal of Internal Review Decisions:

If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this *Evidence of Coverage*. In addition to the arbitration procedures set forth in this *Evidence of Coverage* which may be elected by the member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in Chapter 7.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

Medicare Part D Group Plan member claims:

Complaints and appeals procedures are described in Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)" of this document. The arbitration provisions of this *Evidence of Coverage* apply only to Medicare Part D Group Plan member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this *Evidence of Coverage*, irrespective of the legal theory upon which the claim is asserted.

CHAPTER 10:
Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

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

Catastrophic Coverage Stage – The stage in the Part D drug benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

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

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Formulary (Formulary or Drug List) – A list of prescription drugs covered by our plan.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a payer. When there is more than one payer, there are coordination of benefits rules that decide which one pays first. The primary payer pays what it owes on your bills first, and then sends the rest to the secondary payer to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1, Section 6, and Chapter 9, Section 8, for more information.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. 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. Note: In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

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

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

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

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

Daily cost-sharing rate – A *daily cost-sharing rate* may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your *daily cost-sharing rate* is $1 per day.

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

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Drug – A drug that is not a covered Part D drug, as defined under 42 U.S.C. Section 1395w-102(e).

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 our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Kaiser Foundation Health Plan– Kaiser Foundation Health Plan, Inc., Hawaii Region, is a nonprofit corporation and a Medicare prescription drug plan sponsor called Kaiser Permanente Medicare Part D Group Plan (PDP).

Kaiser Foundation Hospital – A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente – Health Plan, Kaiser Foundation Health Plan, Medical Group, and Kaiser Foundation Hospitals.

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

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

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

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

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

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

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

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

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

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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

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

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

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress.

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

Plan – Kaiser Permanente Medicare Part D Group Plan for PSHB members.

Plan Charges – Plan Charges means for items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).

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

Prior Authorization – Approval in advance to get certain drugs. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

PSHB – The Postal Service Health Benefits Program.

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.

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

Service Area – A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status.

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.

Kaiser Permanente Medicare Part D Group Plan Member Services

Method	Member Services – Contact Information
CALL	1-800-805-2739 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 711 Kapiolani Blvd. Honolulu, HI 96813
WEBSITE	**kp.org**

State Health Insurance 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. Please see *Appendix A* for SHIP contact information.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Appendix A: Important Contact Information

State Health Insurance Program (SHIP)

State	SHIP – Contact Information
Alabama	Alabama Department of Senior Services, Address: 201 Monroe Street, RSA Tower, Suite 350, Montgomery, AL 36130-1851, Phone: 1-800-243-5463, 1-877-425-2243, 334-242-5743, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: alabamaageline.gov/ship/
Alaska	Alaska Medicare Information Office, Address: 1835 Bragaw Street, Suite 350, Anchorage, AK 99508, Phone: 1-800-478-6065, 907-269-3680, TTY: 1-800-770-8973, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.alaska.gov/ship
Arizona	Arizona State Health Insurance Assistance Program, Address: 1789 W. Jefferson Street, Mail Drop 6288, Phoenix, AZ 85007, Phone: 1-800-432-4040, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: des.az.gov/medicare-assistance
Arkansas	Senior Health Insurance Information Program, Address: 1 Commerce Way, Little Rock, AR 72202, Phone: 1-800-224-6330, 501-372-2782, TTY: 501-683-4468, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: shiipar.com
California	California Health Insurance Counseling and Advocacy Program, Address: 2880 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, Phone: 1-800-434-0222, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.ca.gov/hicap
Colorado	State health Insurance Assistance Program, Address: 1560 Broadway, Suite 850, Denver, CO 80202, Phone: 1-888-696-7213, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare
Connecticut	Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening, Address: 55 Farmington Ave., 12th Floor, Hartford, CT 06105, Phone: 1-800-994-9422, TTY: 860-247-0775, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: portal.ct.gov/ads-choices
Delaware	Delaware Medicare Assistance Bureau, Address: 1351 W. North Street, Suite 101, Dover, DE 19904, Phone: 1-800-336-9500, 302-674-7364, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: delawareinsurance.gov/DMAB
District of Columbia	Health Insurance Counseling Project, Address: 500 K Street NE, Washington, DC 20002, Phone: 202-727-8370, TTY: 711, Hours: Monday–Friday 9:30 AM to 4:30 PM, Website: dacl.dc.gov/service/health-insurance-counseling

State	SHIP – Contact Information
Florida	Serving Health Insurance Needs of Elders, Address: 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, Phone: 1-800-963-5337, TTY: 1-800-955-8770, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: floridashine.org
Georgia	Georgia State Health Insurance Assistance Program, Address: 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303, Phone: 1-866-552-4464, Option 4, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.georgia.gov/georgia-ship
Hawaii	Hawaii State Health Insurance Assistance Program, Address: 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, Phone: 1-888-875-9229, 808-586-7299, TTY: 1-866-810-4379, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: hawaiiship.org
Idaho	Senior Health Insurance Benefits Advisors, Address: 700 W. State Street, 3rd Floor, PO Box 83720, Boise, ID 83720-0043, Phone: 1-800-247-4422, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: doi.idaho.gov/SHIBA
Illinois	Senior Health Insurance Program, Address: One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, Phone: 1-800-252-8966, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: 2.illinois.gov/aging/ship
Indiana	State Health Insurance Assistance Program, Address: 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 1-800-452-4800, TTY: 1-866-846-0139, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/ship
Iowa	Senior Health Insurance Information Program, Address: 1963 Bell Ave., Suite 100, Des Moines, IA 50315, Phone: 1-800-351-4664, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: shiip.iowa.gov
Kansas	Senior Health Insurance Counseling for Kansas, Address: New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, Phone: 1-800-860-5260, TTY: 785-291-3167, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kdads.ks.gov/kdads-commissions/aging-services/medicare-programs/shick
Kentucky	State Health Insurance Assistance Program, Address: 275 E. Main Street, Suite 3E-E, Frankfort, KY 40621, Phone: 1-877-293-7447 (Option 2), 502-564-6930, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dail/Pages/ship.aspx
Louisiana	Senior Health Insurance Information Program, Address 1702 N. Third Street, Baton Rouge, LA 70802, Phone: 1-800-259-5300, Option 2, 225-342-5301, TTY: 711 Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: ldi.la.gov/consumers/senior-health-shiip
Maine	Maine State Health Insurance Assistance Program, Address: 11 State

State	SHIP – Contact Information
	House Station, 41 Anthony Avenue, Augusta, ME 04333, Phone: 1-800-262-2232, TTY: 711 Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
Maryland	State Health Insurance Assistance Program, Address: 301 West Preston Street, Suite 1007, Baltimore, MD 21201, Phone: 1-800-243-3425, 410-767-1100, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.maryland.gov/Pages/state-health-insurance-program.aspx
Massachusetts	Serving Health Insurance Needs for Everyone, Address: 1 Ashburton Place, 5th Floor, Boston, MA 02108, Phone: 1-800-243-4636, TTY: 1-800-439-2370, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: mass.gov/health-insurance-counseling
Michigan	Michigan Medicare Assistance Program, Address: 6105 W. St. Joseph, Suite 204, Lansing, MI 48917, Phone: 1-800-803-7174, TTY: 1-888-263-5897, Hours: Monday–Friday 8:00 AM to 7:00 PM, Website: mmapinc.org
Minnesota	Minnesota Senior LinkAge Line, Address: 540 Cedar Street, St. Paul, MN 55164, Phone: 1-800-333-2433, TTY: 1-800-627-3529, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: mn.gov/senior-linkage-line
Mississippi	State Health Insurance Assistance Program, Address: 200 South Lamar St., Jackson, MS 39201, Phone: 1-800-948-3090, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/
Missouri	Missouri State Health Insurance Assistance Program, Address: 601 W. Nifong Blvd. Suite 3A, Columbia, MO 65203, Phone: 1-800-390-3330, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: missouriship.org
Montana	Montana State Health Insurance Assistance Program, Address: 1100 N Last Chance Gulch, 4th Floor, Helena, MT 59601, Phone: 1-800-551-3191, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/sltc/aging/ship
Nebraska	Nebraska SHIP, Address: 1526 K Street, Suite 201, Lincoln, NE 68508, Phone: 1-800-234-7119, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: doi.nebraska.gov/consumer/senior-health
Nevada	Nevada Medicare Assistance Program, Address: 3416 Goni Road, Suite D-132, Carson City, NV 89706, Phone: 1-800-307-4444, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: nevadacareconnection.org/care-options/types-of-services/healthcare/medicare-assistance-program-map/

State	SHIP – Contact Information
New Hampshire	New Hampshire State Health Insurance Assistance Program, Address: 129 Pleasant Street, Concord, NH 03301, Phone: 1-866-634-9412, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: servicelink.nh.gov/medicare/index.htm
New Jersey	State Health Insurance Assistance Program, Address: Division of Aging Services, P.O. Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-8820, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: nj.gov/humanservices/doas/services/q-z/ship
New Mexico	New Mexico ADRC – State Health Insurance Assistance Program, Address: 2550 Cerrillos Road, Santa Fe, NM 87505, Phone: 1-800-432-2080, TTY: 505-476-4937, Hours: Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: aging.nm.gov
New York	Health Insurance Information, Counseling and Assistance, Address: 2 Empire State Plaza, 5th Floor, Albany, NY 12223, Phone: 1-800-701-0501, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.ny.gov/health-insurance-information-counseling-and-assistance
North Carolina	Seniors' Health Insurance Information Program, Address: NC Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, Phone: 1-855-408-1212, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
North Dakota	State health Insurance Counseling Program, Address: 600 E. Boulevard Ave., Bismarck, ND 58505-0320, Phone: 1-888-575-6611, TTY: 1-800-366-6888, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.nd.gov/shic-medicare
Ohio	Ohio Senior Health Insurance Information Program, Address: 50 W. Town Street, Suite 300, Columbus, OH 43215, Phone: 1-800-686-1578, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.ohio.gov/about-us/divisions/oshiip
Oklahoma	Senior Health Insurance Counseling Program, Address: 400 NE 50th Street, Oklahoma City, OK 73105, Phone: 1-800-763-2828, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: map.oid.ok.gov
Oregon	Senior Health Insurance Benefits Assistance, Address: 500 Summer Street NE, Suite E-12, Salem, OR 97301, Phone: 1-800-722-4134, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: shiba.oregon.gov
Pennsylvania	PA MEDI – Pennsylvania Medicare Education and Decision Insight, Address: 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, Phone: 1-800-783-7067, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.pa.gov

State	SHIP – Contact Information
Rhode Island	Senior Health Insurance Program, Address: 25 Howard Ave., Building 57, Cranston, RI 02920, Phone: 1-888-884-8721, TTY: 401-462-0740, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oha.ri.gov/Medicare
South Carolina	State Health Insurance Assistance Program, Address: 1301 Gervais Street, Suite 350, Columbia, SC 29201, Phone:1-800-868-9095, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.sc.gov
South Dakota	Senior Health Information and Insurance Education, Address: 700 Governors Drive, Pierre, SD 57501-2291, Phone: 1-800-536-8197, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:30 PM, Website: shiine.net
Tennessee	State health Insurance Assistance Program, Address: 502 Deaderick Street, 9th Floor, Nashville, TN 37243, Phone: 1-877-801-0044, TTY: 1-800-848-0299, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship
Texas	Health Information, Counseling, and Advocacy Program, Address: 701 W. 51st Street, MC W206 Austin, TX 78751, Phone: 1-800-252-9240, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/medicare
Utah	Senior Health Insurance Information Program, Address: 195 N. 1950 West, Salt Lake City, UT 84116, Phone: 1-800-541-7735, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: daas.utah.gov/seniors
Vermont	State Health Insurance Assistance Program, Address: 27 Main Street, Suite 14, Montpelier, VT 05602, Phone: 1-800-642-5119, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: vermont4a.org/medicare-information
Virginia	Virginia Insurance Counseling & Assistance Program, Address: 1610 Forest Ave., Suite 100, Henrico, VA 23229, Phone: 1-800-552-3402, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: vda.virginia.gov/vicap.htm
Washington	Statewide Health Insurance Benefits Advisors, Address: 5000 Capitol Blvd., Tumwater, WA 98504-0256, Phone: 1-800-562-6900, **TTY**: 360-586-0241, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba
West Virginia	State Health Insurance Assistance Program, Address: 1900 Kanawha Blvd. East, (3rd Floor Town Center Mall) Charleston, WV 25305-0160, Phone: 1-877-987-4463, 304-558-3317, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: wvship.org
Wisconsin	State Health Insurance Assistance Program, Address: 1 W. Wilson Street, Madison, WI 53703, Phone: 1-800-242-1060, TTY: 711,

State	SHIP – Contact Information
	Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
Wyoming	State Health Insurance Assistance Program, Address: 106 W. Adams Ave., Riverton, WY 82501, Phone: 1-800-856-4398, TTY: 711, Hours: Monday–Friday 7:00 AM to 4:00 PM, Website: wyomingseniors.com

Quality Improvement Organization (QIO)

Region	QIO – Contact Information
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-319-8452, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: acentraqio.com
Region 2: New Jersey, New York	Livanta, Address: 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-866-815-5440, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: livantaqio.cms.gov/en
Region 3: Delaware, Maryland, Pennsylvania, Virginia, District of Columbia, West Virginia	Livanta, Address: 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-866-396-4646, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: livantaqio.cms.gov/en
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-317-0751, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: acentraqio.com
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Livanta, Address: 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-524-9900, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: livantaqio.cms.gov/en
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-315-0636, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: acentraqio.com
Region 7: Iowa, Kansas, Missouri, Nebraska	Livanta, Address: 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-755-5580, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: livantaqio.cms.gov/en

Region	QIO – Contact Information
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-317-0891, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: acentraqio.com
Region 9: Arizona, California, Hawaii, Nevada, Pacific Islands	Livanta, Address: 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-877-588-1123, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: livantaqio.cms.gov/en
Region 10: Alaska, Idaho, Oregon, Washington	Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-305-6759, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Website: acentraqio.com

Medicaid

State	Medicaid Program – Contact Information
Alabama	Alabama Medicaid Agency, Address: PO Box 5624, Montgomery, AL 36103, Phone: 1-800-362-1504, 334-242-5000, TTY: 1-800-253-0799, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: medicaid.alabama.gov/content/10.0_Contact/10.1_Medicaid_Contacts/10.1.1_Medicaid_Locations.aspx
Alaska	Alaska Dept. of Health Division of Public Assistance, Address: PO Box 110640, 350 Main Street, Room 304, Juneau, AK 99811-0640, Phone: 1-800-780-9972 (coverage or billing), 1-800-478-7778 (eligibility), TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.alaska.gov/dhcs/Pages/default.aspx
Arizona	Arizona Health Care Cost Containment System (AHCCCS), Address: 801 E. Jefferson Street, Phoenix, AZ 85034, Phone: 1-800-654-8713, 602-417-4000, TTY: 1-800-842-6520, Hours: Monday–Friday 7:00 AM to 9:00 PM, Saturday 8:00 AM to 6:00 PM, Website: azahcccs.gov
Arkansas	Arkansas Medicaid, Address: PO Box 1437, Slot S401, Little Rock, AR 72203-1437, Phone: 1-800-482-8988, 1-800-482-5431, TTY: 501-682-8933, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: humanservices.arkansas.gov/divisions-shared-services/medical-services
California	California Department of Health Services Medi-Cal, Address: PO Box 138008, Sacramento, CA 95813-8008, Phone: 1-800-541-5555, 916-636-1980, TTY: 1-866-784-2595, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhcs.ca.gov
Colorado	HealthFirst Colorado, Address: 1570 Grant Street, Denver, CO 80203-1818, Phone: 1-800-221-3943, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: healthfirstcolorado.com
Connecticut	HUSKY, Connecticut's Health Care for Children & Adults, Address: 55 Farmington Ave., Hartford, CT 06105-3724, Phone: 1-877-284-8759, TTY:

State	Medicaid Program – Contact Information
	1-866-492-5276, Hours: Monday–Friday 7:30 AM to 4:00 PM, Website: portal.ct.gov/husky/welcome
Delaware	Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA), Address: DHSS Herman Holloway Campus, Lewis Building, 1901 N. DuPont Highway, New Castle, DE 19720, Phone: 1-866-843-7212, 302-571-4900, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhss.delaware.gov/dhss/dmma/medicaid.html
District of Columbia	The Department of Health Care Finance – DHCF, Address: 441 4th Street NW, 900S, Washington, DC 20001, Phone: 202-442-5988, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, Website: dhcf.dc.gov/service/medicaid
Florida	Florida Agency for Health Care Administration, Division of Medicaid, Address: 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308, Phone: 1-877-711-3662, TTY: 1-866-467-4970, Hours: Monday–Thursday, 8:00 AM to 8:00 PM, Friday 8:00 AM to 7:00 PM, Website: flmedicaidmanagedcare.com/home
Georgia	Georgia Medicaid, Address: Division of Family and Children Services, Customer Contact Center, 2 Peachtree Street NW, 19th Floor, Atlanta, GA 30303, Phone: 1-877-423-4746, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.georgia.gov/programs
Hawaii	Hawaii Med-QUEST Division, Address: 1390 Miller Street, Suite 209, Honolulu, HI 96813-2403, Phone: 808-524-3370 (Oahu), 1-800-316-8005 (Neighbor Islands), TTY: 711, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: medquest.hawaii.gov
Idaho	Idaho Department of Health and Welfare, Address: PO Box 83720, Boise, ID 83720-0036, Phone: 1-877-456-1233, TTY: 1-888-791-3004, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: idalink.idaho.gov
Illinois	Illinois Department of Healthcare and Family Services, Address: 201 S. Grand Ave. E, Springfield IL 62704, Phone: 1-800-843-6154, 1-866-468-7543, TTY: 1-800-447-6404,1-877-204-1012, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hfs.illinois.gov
Indiana	Indiana Medicaid, Address: 402 W. Washington Street, Room W392, PO Box 7083, Indianapolis, IN 46204, Phone: 1-800-403-0864, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/medicaid
Iowa	IA Health Link, Address: PO Box 36510, Des Moines, IA 50315, Phone: 1-800-338-8366, 515-256-4606, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link
Kansas	KanCare Medicaid for Kansas, Address: PO Box 3599, Topeka, KS 66601, Phone: 1-800-792-4884, TTY: 1-800-766-3777, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kancare.ks.gov
Kentucky	Kentucky Cabinet for Health and Family Services, Department for Medicaid Services, Address: 275 E. Main St. 6W-A, Frankfort, KY 40621,

State	Medicaid Program – Contact Information
	Phone: 1-800-635-2570, 1-855-306-8959, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dms/Pages/default.aspx
Louisiana	Louisiana Department of Health, Address: PO Box 629, Baton Rouge, LA 70821-0629, Phone: 1-888-342-6207, TTY: 1-800-220-5404, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ldh.la.gov/subhome/1
Maine	Office of MaineCare Services, Address: Office for Family Independence, 114 Corn Shop Lane, Farmington, ME 04938, Phone: 1-855-797-4357, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: maine.gov/dhhs/ofi/programs-services/health-care-assistance
Maryland	Maryland Medicaid, Address: Herbert R. O'Conor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, Phone: 1-877-463-3464, 1-855-642-8572, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: health.maryland.gov/mmcp/Pages/home.aspx
Massachusetts	MassHealth, Address: 100 Hancock St., 1st Floor, Quincy, MA 02171, Phone: 1-800-841-2900, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mass.gov/orgs/masshealth
Michigan	Michigan Medicaid Program, Address: Capitol View Building, 201 Townsend Street, Lansing, MI 48913, Phone: 1-800-642-3195, 517-373-3740, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: michigan.gov/mdhhs/assistance-programs/medicaid
Minnesota	Minnesota Department of Human Services, Medical Assistance (MA), Address: PO Box 64993, St. Paul, MN 55164-0993, Phone: 1-800-657-3739, 651-431-2670, TTY: 1-800-627-3529, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Mississippi	Mississippi Division of Medicaid, Address: MS Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201, Phone: 1-800-421-2408, 601-659-6050, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.ms.gov
Missouri	MO HealthNet, Address: 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, Phone: 1-800-392-2161, 573-751-4815, TTY: 1-800-735-2466, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mydss.mo.gov/healthcare
Montana	Montana Medicaid and HMK Plus, Address: 111 North Sanders Street, Helena, MT 59601-4520, PO Box 4210, Helena, MT 59604-4210, Phone: 1-800-362-8312, 1-888-706-1535, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
Nebraska	Nebraska Department of Health and Human Services System, Address: 301 Centennial Mall South, Lincoln, NE 68508, Phone: 402-471-3121, TTY: 1-800-833-7352, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhs.ne.gov/Pages/General-Medicaid-Information.aspx
Nevada	Nevada Department of Health and Human Services, Address: Nevada Medicaid, Customer Service, PO Box 30042, Reno, NV 89520-3042, Phone:

State	Medicaid Program – Contact Information
	1-877-638-3472, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.nv.gov/contactinfo.aspx
New Hampshire	New Hampshire Department of Health and Human Services, Address: Division of Medicaid Services, 129 Pleasant Street, Concord, NH 03301, Phone: 1-844-275-3447, TTY: 1-800-735-2964, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhhs.nh.gov/programs-services/medicaid
New Jersey	NJ Department of Human Services, Division of Medical Assistance & Health Services, Address: NJ Department of Human Services, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, Phone: 1-800-701-0710, TTY: 1-800-701-0720, Hours: Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM, Website: nj.gov/humanservices/dmahs/staff/info
New Mexico	Centennial Care, Address: NM Human Services Department, PO Box 2348, Santa Fe, NM 87504, Phone: 1-800-283-4465, TTY: 711, Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: hca.nm.gov
New York	The New York Department of Health, Address: New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, Phone: 1-800-541-2831, TTY: 711, Hours: Monday–Friday 8:00 AM to 8:00 PM, Saturday-Sunday 9:00 AM to 1:00 PM, Website: health.ny.gov/health_care/medicaid
North Carolina	NC Medicaid, Division of Health Benefits, Address: 2501 Mail Service Center, Raleigh, NC 27699-2501, Phone: 1-888-245-0179, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.ncdhhs.gov
North Dakota	North Dakota Department of Human Services, Medical Services Division, Address: 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250, Phone: 1-800-755-2604, 701-328-7068, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.nd.gov/healthcare/medicaid
Ohio	Ohio Department of Medicaid, Address: 50 W. Town Street, Suite 400, Columbus, OH 43215, Phone: 1-800-324-8680, TTY: 711, Hours: Monday–Friday 7:00 AM to 8:00 PM, Saturday 8:00 AM to 4:00 PM, Website: medicaid.ohio.gov
Oklahoma	SoonerCare, Address: Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, Phone: 1-800-987-7767, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oklahoma.gov/ohca.html
Oregon	Oregon Health Plan (OHP), Address: PO Box 14015, Salem, OR 97309, Phone: 1-800-273-0557, TTY: 711, Hours: Monday–Friday 7:00 AM to 6:00 PM, Website: oregon.gov/oha/HSD/OHP/Pages/Contact-Us.aspx
Pennsylvania	Pennsylvania Department of Human Services, Address: 625 Forster Street, Harrisburg, PA 17120, Phone: 1-800-692-7462, TTY: 1-800-451-5886, 711, Hours: Monday–Friday 8:30 AM to 4:45 PM, Website: pa.gov/en/agencies/dhs/resources/medicaid.html
Rhode Island	Rhode Island Department of Human Services, Address: 3 West Road, Cranston, RI 02920, Phone: 1-855-697-4347, TTY: 711, Hours: Monday,

State	Medicaid Program – Contact Information
	Tuesday, Thursday, Friday 8:30 AM to 3:00 PM, except holidays, Website: eohhs.ri.gov/consumer/health-care
South Carolina	South Carolina Healthy Connections Medicaid, Address: SCDHHS, PO Box 100101, Columbia, SC 29202, Phone: 1-888-549-0820, TTY: 1-888-842-3620, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: apply.scdhhs.gov/CitizenPortal
South Dakota	South Dakota Medicaid, Address: 700 Governors Drive, Pierre, SD 57501, Phone: 1-800-597-1603, 605-773-3165, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dss.sd.gov/medicaid
Tennessee	TennCare, Address: 310 Great Circle Road, Nashville, TN 37243, Phone: 1-855-259-0701 (Applications), 1-800-342-3145 (General), TTY: 1-877-779-3103, Hours: Monday–Friday 7:00 AM to 6:00 PM, Website: tn.gov/tenncare
Texas	Texas Health and Human Services Commission, Address: 4900 N. Lamar Boulevard, Austin, TX 78751-2316, Phone: 1-800-252-8263, TTY: 1-800-735-2989, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/medicaid-chip
Utah	Utah Department of Health Medicaid, Address: PO Box 143106, Salt Lake City, UT 84114-3106, Phone: 1-800-662-9651, 801-538-6155 (Customer Service); 801-526-0950, 1-866-435-7414 (Eligibility), TTY: 711, Hours: Monday, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM and Thursday 11:00 AM to 5:00 PM, Website: medicaid.utah.gov
Vermont	Vermont Medicaid Programs, Address: Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250-8427, 1-855-899-9600, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dvha.vermont.gov/members/contact-us
Virginia	Cardinal Care Virginia Medicaid, Address: 600 E. Broad Street, Suite 1300, Richmond, VA 23219, Phone: 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), TTY: 1-888-221-1590, Hours: Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, Website: dmas.virginia.gov
Washington	Washington Apple Health, Address: Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501, Phone: 1-800-562-3022, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: hca.wa.gov
West Virginia	West Virginia Department of Health & Human Resources, Bureau for Medical Services, Address: One Davis Square, Suite 100 East, Charleston, WV 25301, Phone: 1-877-716-1212, 304-558-1700, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhr.wv.gov/Pages/default.aspx
Wisconsin	Wisconsin Department of Health Services, Address: Division of Medicaid Services, PO Box 309, Madison, WI 53707-0309, Phone: 1-800-362-3002, 608-266-8922, TTY: 1-800-947-3529, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhs.wisconsin.gov/dms/index.htm

State	Medicaid Program – Contact Information
Wyoming	Wyoming Department of Health, Healthcare Financing Division, Address: Customer Service Center, 3001 E. Pershing Blvd., Suite 125, Cheyenne, WY 82001, Phone: 1-855-294-2127, 307-777-7531, TTY: 1-855-329-5204, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.wyo.gov/healthcarefin/apply

State Pharmaceutical Assistance Program (SPAP)

State	SPAP – Contact Information
Alabama	SenioRx Prescription Assistance Program, Address: RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, Phone: 1-877-425-2243, 334-242-5743, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: alabamaageline.gov/seniorx
Colorado	Bridging the Gap, Address: 4300 Cherry Creek Drive South, Denver, CO 80246, Phone: 303-692-2783, 303-692-2716, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM,
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled, Address: PO Box 5011, Hartford, CT 06102, Phone: 1-800-423-5026, 860-832-9265, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: q1medicare.com/PartD-SPAP-ConnecticutElderly-Disabled.php
Delaware	Delaware Prescription Assistance Program, Address: 511 W 8th St, Wilmington, DE 19801, Phone: 1-800-345-6785, TTY: 711 Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: q1medicare.com/PartD-PAPDelawareStateElderlyDisabled.php
Indiana	HoosierRx, Address: 402 W. Washington Street, Room 372, Indianapolis, IN 46204, Phone: 1-866-267-4679, 317-234-1381, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/medicaid/members/member-programs/hoosierrx
Maine	Maine Low Cost Drugs for the Elderly or Disabled Program, Address: Phone:, TTY: 1-800-606-0215, Hours: q1medicare.com/PartD-SPAPMaineLowCstRxElderlyDisabled.php
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP), Address: Maryland – SPDAP c/o International Software Systems Inc., PO Box 749, Greenbelt, Maryland 20768-0749, Phone: 1-800-551-5995, TTY: 1-800-877-5156, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: marylandspdap.com
Massachusetts	Prescription Advantage, Address: PO Box 15153, Worcester, MA 01615, Phone: 1-800-243-4636 EXT: 2, TTY: 1-877-610-0241, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: mass.gov/info-details/prescription-advantage
Missouri	Missouri Rx Plan (MORx), Address: PO Box 2700, Jefferson City, MO 65102, Phone: 1-800-375-1406, 573-751-6963, TTY:

State	SPAP – Contact Information
	1-800-735-2966, Hours: Monday–Friday 6:00 AM to 6:00 PM, Website: mydss.mo.gov/mhd/morx-pharmacist-faqs
Montana	Montana Big Sky Rx Program, Address: PO Box 202915, Helena, MT 59620-2915, Phone: 1-866-369-1233, 406-444-1233, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
New Jersey	New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD), Address: PAAD-HAAAD, Department of Human Services, PO Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-9745, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: nj.gov/humanservices/doas/services/l-p/paad New Jersey Senior Gold Prescription Discount Program, Address: Division of Aging Services, PO Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-9745, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: nj.gov/humanservices/doas/services/q-z/senior-gold
New York	Elderly Pharmaceutical Insurance Coverage (EPIC) Program, Address: EPIC, PO Box 15018, Albany, NY 12212-5018, Phone: 1-800-332-3742, TTY: 1-800-290-9138, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.ny.gov/health_care/epic
Pennsylvania	PACE/PACENET Prescription Assistance Program, Address: Pennsylvania Department of Aging, PO Box 8806, Harrisburg, PA 17105-8806, Phone: 1-800-225-7223, 717-651-3600, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: q1medicare.com/PartD-SPAPPennsylvania-ElderlyDisabled.php Special Pharmaceutical Benefits Program - Mental Health, Address: Department of Public Welfare, Special Pharmaceutical Benefits Program – SPBPMH, P.O. BOX 8808, Harrisburg, PA 17105, Phone: 1-800-922-9384, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: q1medicare.com/PartD-SPAPPennsylvania-ElderlyDisabled.php
Rhode Island	RI Pharmaceutical Assistance to Elders (RIPAE), Address: Attention RIPAE, Rhode Island Department of Elderly Affairs, Hazard Building, Second Floor, 74 West Road, Cranston, RI 02920, Phone: 401-462-3000, 401-462-0740, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: q1medicare.com/PartD-SPAPRhodeIslandRIPAE-PharmAssist.php
Vermont	VPharm and Healthy Vermonters Programs, Address: Green Mountain Care, Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250-8427, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:00 PM, Website: dvha.vermont.gov/members/prescription-assistance
Wisconsin	SeniorCare, Address: Senior Care, PO Box 6710, Madison, WI 53716-0710, Phone: 1-800-657-2038, TTY: 711, Hours: Monday–

State	SPAP – Contact Information
	Friday 8:00 AM to 4:30 PM, Website: dhs.wisconsin.gov/seniorcare/index.htm

AIDS Drug Assistance Programs (ADAP)

State	ADAP – Contact Information
Alabama	Alabama AIDS Drug Assistance Program (ADAP), Address: Office of HIV Prevention and Care, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104, Phone: 1-866-574-9964, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: alabamapublichealth.gov/hiv/adap.html
Alaska	Alaska AIDS Drug Assistance Program (ADAP), Address: Anchorage – 1057 W. Fireweed Lane, Suite 102, Anchorage, AK 99503 Juneau – 225 Front Street, Suite 103-A, Juneau, AK 99801, Phone: 1-800-478-AIDS (2437), Anchorage: 907-263-2050, Juneau: 907-500-7465, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: alaskanaids.org/client-services/aids-drug-assistance-program-adap
Arizona	Arizona AIDS Drug Assistance Program (ADAP), Address: Arizona Department of Health Services, 150 N. 18th Ave., Phoenix, AZ 85007, Phone: 1-800-334-1540, 602-364-3610, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/index.php
Arkansas	Ryan White Program, Arkansas AIDS Drug Assistance Program (ADAP), Address: 4815 W. Markham, Little Rock, AR 72205, Phone: 1-800-462-0599, Option 3, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: healthy.arkansas.gov/programsservices/%20topics/ryan-white-program
California	AIDS Drug Assistance Program (ADAP), Address: PO Box 997377, MS 0500, Sacramento, CA 95899-7377, Phone: 1-833-422-4255, 916-558-1784, TTY: 711, Hours: Monday–Friday 8:00 AM to 8:00 PM, Saturday & Sunday 8:00 AM to 5:00 PM, Website: cdph.ca.gov/Programs/CID/DOA/pages/oaadap.aspx
Colorado	State Drug Assistance Program (SDAP), Address: 4300 Cherry Creek Drive South, Denver, CO 80246, Phone: 303-692-2716, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: cdphe.colorado.gov/state-drug-assistance-program
Connecticut	Connecticut AIDS Drug Assistance Program (CADAP), Address: State of CT Department of Public Health c/o Magellan Rx Management, PO Box 13001, Albany, NY 12212-3001, Phone: 1-800-424-3310, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ctdph.magellanrx.com
Delaware	Delaware AIDS Drug Assistance Program (ADAP), Address: Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901, Phone: 302-744-1050, Option 1, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhss.delaware.gov/dph/dpc/hivtreatment.html
District of Columbia	DC AIDS Drug Assistance Program (ADAP), Address: 899 North Capitol Street NE, Washington, DC 20002, Phone: 202-671-4815, TTY: 711, Hours: Monday–

State	ADAP – Contact Information
	Friday 8:15 AM to 4:45 PM, except district holidays, Website: dchealth.dc.gov/DC-ADAP
Florida	AIDS Drug Assistance Program (ADAP), Address: HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, Phone: 1-800-352-2437, 844-381-2327, TTY: 1-888-503-7118, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: floridahealth.gov/diseases-and-conditions/aids/adap
Georgia	Georgia AIDS Drug Assistance Program (ADAP), Address: 200 Piedmont Avenue, SE, Atlanta, GA 30334, Phone: 404-656-9805, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Hawaii	Hawaii HIV Drug Assistance Program (HDAP), Address: 3627 Kilauea Ave., Suite 306, Honolulu, HI 96816, Phone: 808-733-9360, TTY: 711, Hours: Monday–Friday 7:45 AM to 2:30 PM, Website: /health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services
Idaho	Idaho AIDS Drug Assistance Program (ADAP), Address: 450 W. State Street, PO Box 83720, Boise, ID 83720-0036, Phone: 208-334-5612, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv
Illinois	Illinois AIDS Drug Assistance Program (ADAP), Address: 525 W. Jefferson Street, 1st Floor, Springfield, IL 62761, Phone: 1-800-825-3518, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services.html
Indiana	Indiana AIDS Drug Assistance Program (ADAP), Address: 2 N. Meridian Street, Suite 6C, Indianapolis, IN 46204, Phone: 1-866-588-4948, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: in.gov/health/hiv-std-viral-hepatitis/hiv-services
Iowa	Iowa AIDS Drug Assistance Program (ADAP), Address: Lucas State Office Building, 321 E. 12th Street, Des Moines, IA 50319-0075, Phone: 515-204-3746, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: hhs.iowa.gov/public-health/hiv-stis-and-hepatitis/hivaids-program
Kansas	Kansas AIDS Drug Assistance Program (ADAP), Address: Curtis State Office Building, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, Phone: 785-296-6174, Option 5, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kdhe.ks.gov/355/The-Ryan-White-Part-B-Program
Kentucky	Kentucky AIDS Drug Assistance Program (KADAP), Address: 275 E. Main Street, HS2E-C,Frankfort, KY 40621, Phone: 1-800-420-7431, 502-564-6539, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx
Louisiana	Louisiana Health Access Program (LA HAP), Address: 1450 Poydras Street, Suite 2136, New Orleans, LA 70112, Phone: 504-568-7474, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: lahap.org

State	ADAP – Contact Information
Maine	Maine AIDS Drug Assistance Program (ADAP), Address: Maine Ryan White Program, 40 State House Station, Augusta, ME 04330, Phone: 207-287-3747, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/ryan-white-b.shtml
Maryland	Maryland AIDS Drug Assistance Program (MADAP), Address: 1223 W. Pratt Street, Baltimore, MD 21223, Phone: 1-800-205-6308, 410-767-6535, TTY: 1-800-735-2258, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
Massachusetts	Massachusetts HIV/AIDS Drug Assistance Program (HDAP), Address: Community Resource Initiative, Attention – HDHP, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129, Phone: 1-800-228-2714, 617-502-1700, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: crihealth.org/contact/#HDAP
Michigan	Michigan HIV/AIDS Drug Assistance Program (MIDAP), Address: Michigan Drug Assistance Program, HIV Care Section, Division of HIV/STI Programs, Client, and Partner Services, Bureau of HIV and STI Programs, Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909, Phone: 1-888-826-6565, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program/michigan-drug-assistance-program
Minnesota	Minnesota Aids Drug Assistance Program (ADAP), Address: Minnesota Department of Human Services, HIV/AIDS Programs, PO Box 64972, St. Paul, MN 55164-0972, Phone: 1-800-657-3761, 651-431-2414, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp
Mississippi	Mississippi AIDS Drug Assistance Program (ADAP), Address: Office of STD/HIV Care and Treatment Division, PO Box 1700, Jackson, MS 39215, Phone: 1-888-343-7373, 601-362-4879, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: msdh.ms.gov/msdhsite/_static/14,13047,150.html
Missouri	Missouri HIV/AIDS Case Management Program, Address: Bureau of HIV, STD, and Hepatitis, Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102, Phone: 573-751-6439, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
Montana	Montana AIDS Drug Assistance Program (ADAP), Address: Cogswell Building, Room C-211, 1400 Broadway, Helena, MT 59620, Phone: 406-444-3565, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
Nebraska	Nebraska Ryan White AIDS Drug Assistance Program (ADAP), Address: Nebraska Department of Health & Human Services, PO Box 95026, Lincoln, NE

State	ADAP – Contact Information
	68509-5026, Phone: 402-471-2101, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhs.ne.gov/Pages/HIV-Care.aspx
Nevada	Nevada AIDS Drug Assistance Program (ADAP)/NV Medication Assistance Program, Address: 2290 S. Jones Blvd., Suite 110, Las Vegas, Nevada 89146, Phone: 702-486-0768, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: endhivnevada.org/ryan-white-care
New Hampshire	New Hampshire AIDS Drug Assistance Program (ADAP), Address: 29 Hazen Drive, Concord, NH 03301, Phone: 1-800-852-3345 ext. 4502, 603-271-4502, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap
New Jersey	New Jersey AIDS Drug Distribution Program (ADDP), Address: PO Box 722, Trenton, NJ 08625-0722, Phone: 1-877-613-4533, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml
New Mexico	New Mexico AIDS Drug Assistance Program (ADAP), Address: HIV Services Program, 1190 S. St. Francis Drive, Room S-1204, Santa Fe, NM 87505, Phone: 505-476-3628, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: nmhealth.org/about/phd/idb/hats
New York	New York AIDS Drug Assistance Program (ADAP), Address: HIV Uninsured Care Programs, Empire Station, PO Box 2052, Albany, NY 12220-0052, Phone: 1-800-542-2437,1-844-682-4058, 518-459-1641, TTY: 518-459-0121, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.ny.gov/diseases/aids/general/resources/adap
North Carolina	North Carolina HIV Medication Assistance Program (NC HMAP), Address: NC Department of Health and Human Services Division of Public Health, Epidemiology Section Communicable Disease Branch, 1907 Mail Service Center, Raleigh, NC 27699, Phone: 1-877-466-2232, 919-733-9161,TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: epi.dph.ncdhhs.gov/cd/hiv/hmap.html
North Dakota	North Dakota AIDS Drug Assistance Program (ADAP), Address: North Dakota Department of Health, Division of Disease Control, 2635 E. Main Avenue, PO Box 5520, Bismarck, ND 58505, Phone: 1-800-472-2180, 701-328-2378, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.nd.gov/health/diseases-conditions-and-immunization/north-dakota-ryan-white-part-b-program
Ohio	Ohio HIV Drug Assistance Program (OHDAP), Address: Ohio Department of Health, 246 N. High Street, Columbus, OH 43215, Phone: 1-800-777-4775, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program
Oklahoma	Oklahoma AIDS Drug Assistance Program (ADAP), Address: Oklahoma State Department of Health, Sexual Health and Harm Reduction Services, 123 Robert S. Kerr Avenue, Suite 1702, Oklahoma City, OK 73102-6406, Phone:

State	ADAP – Contact Information
	405-426-8400, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.html
Oregon	Oregon CAREAssist, Address: 800 NE Oregon Street, Suite 1105, Portland, OR 97232, Phone: 971-673-0144, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
Pennsylvania	Pennsylvania Special Pharmaceutical Benefits Program – HIV/AIDS, Address: Department of Health Special Pharmaceutical Benefits Program, PO Box 8808, Harrisburg, PA 17105-8808, Phone: 1-800-922-9384, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
Rhode Island	Rhode Island AIDS Drug Assistance Program (ADAP), Address: Executive Office of Health & Human Services, Virks Building, 3 West Rd., Suite 227, Cranston, RI 02920, Phone: 401-462-3295, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx
South Carolina	South Carolina AIDS Drug Assistance Program (ADAP), Address: SC AIDS Drug Assistance Program, 3rd Floor, Mills/Jarrett Box 101106, Columbia, SC 29211, Phone: 1-800-856-9954, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: scdhec.gov/aids-drug-assistance-program
South Dakota	South Dakota AIDS Drug Assistance Program (ADAP), Address: Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th Street, Pierre, SD 57501-1700, Phone: 1-800-592-1861, 605-773-3737, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: doh.sd.gov/topics/diseases/infectious/reportable-communicable-diseases/hivaids/ryan-white-part-b-program
Tennessee	Tennessee AIDS Drug Assistance Program (ADAP), Address: TN Department of Health, HIV/STD Program, Ryan White Part B Services, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243, Phone: 1-800-525-2437, 615-741-7500, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
Texas	Texas HIV Medication Program (THMP), Address: ATTN: MSJA, MC 1873, PO Box 149347, Austin, TX 78714-9347, Phone: 1-800-255-1090, 737-255-4300, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dshs.texas.gov/hivstd/meds
Utah	Utah Ryan White Part B ADAP AIDS Drug Assistance Program, Address: Utah Department of Health, Bureau of Epidemiology, 288 N 1460 West, PO Box 142104, Salt Lake City, UT 84114-2104, Phone: 801-538-6191, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ptc.health.utah.gov/ryan-white

State	ADAP – Contact Information
Vermont	Vermont Medication Assistance Program (VMAP), Address: 108 Cherry Street, PO Box 70, Burlington, VT 05402-0070, Phone: 802-951-4005, 1-800-464-4343 ext. 4005, TTY: 711, Hours: Monday–Friday 7:45 AM to 3:30 PM, Website: healthvermont.gov/disease-control/hiv/hiv-care
Virginia	Virginia Medication Assistance Program (VA MAP), Address: Department of Health, 109 Governor Street, Richmond, VA 23219, Phone: 1-855-362-0658, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: vdh.virginia.gov/disease-prevention/vamap
Washington	Washington Early Intervention Program (EIP), Address: Client Services, PO Box 47841, Olympia, WA 98504, Phone: 1-877-376-9316, 360-236-3426, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program
West Virginia	West Virginia AIDS Drug Assistance Program (ADAP), Address: Jay Adams, HIV Care Coordinator, PO Box 6360, Wheeling, WV 26003, Phone: 304-232-6822, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: oeps.wv.gov/rwp/pages/default.aspx
Wisconsin	Wisconsin AIDS/HIV Drug Assistance Program (ADAP), Address: Division of Public Health, Attn: ADAP, PO Box 2659, Madison, WI 53701, Phone: 1-800-991-5532, 608-261-6952, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhs.wisconsin.gov/hiv/adap.htm
Wyoming	Wyoming AIDS Drug Assistance Program (ADAP), Address: Wyoming Department of Health, 401 Hathaway Building, Cheyenne, WY 82002, Phone: 1-866-571-0944, (307) 777-7656, TTY: 711, Hours: Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-program/hiv-treatment-resources-for-patients

Notice of Nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-805-2739** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 711 Kapiolani Blvd, Honolulu, HI 96813 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697** (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

1127746096 HI
July 2023

KAISER PERMANENTE®

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-805-2739** (TTY **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-805-2739** (TTY **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-800-805-2739** (TTY **711**)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-805-2739** (TTY **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-805-2739** (TTY **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-805-2739** (TTY **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-805-2739** (TTY **711**). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-805-2739** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

KAISER PERMANENTE®

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-805-2739** (TTY **711**). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-805-2739** (TTY **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-805-2739** (TTY **711**). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-805-2739** (TTY **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-805-2739** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-805-2739** (TTY **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-805-2739** (TTY **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-805-2739** (TTY **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-800-805-2739** (TTY **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Tongan: 'Oku 'i ai 'emau sēvesi fakatonu lea ta'etotongi ke ne ala tali ha'o ngaahi fehu'i fekau'aki mo 'emau palani mo'ui leleí pe faito'ó. Te ke ma'u ha tokotaha fakatonulea 'i ha'o fetu'utaki ki he **1-800-805-2739** (TTY **711**). 'E 'i ai ha tokotaha 'oku lea Faka-Pilitānia ke ne tokoni'i koe. Ko e sēvesi ta'etotongi eni.

Ilocano: Addaankami kadagiti libre a serbisio ti mangitarus tapno sungbatan ti aniaman a saludsod nga addaan ka maipapan ti plano iti salun-at wenno agasmi. Tapno mangala ti mangitarus, maidawat a tawagannakam iti **1-800-805-2739** (TTY **711**). Maysa a tao nga agsasao iti Ilocano ti makatulong kenka. Daytoy ket libre a serbisio.

Pohnpeian: Mie sahpis ni soh isepe oang kawehwe peidek kan me komwi sohte wehwehki oang palien roson mwahu de wasa me pwain kohdahn wini. Komwi en kak iang alehdi sawas wet, komw telepwohndo reht ni **1-800-805-2739** (TTY **711**). Mie me kak Lokaiahn Pohnpei me pahn seweseiuk. Sawas wet sohte isepe.

Samoan: E iai a matou auaunaga faaliliuupu e tali i soo sau fesili e uiga i lou soifua maloloina poo fuafuaga o vailaau. A fia maua se faaliliuupu, na’o lou valaau mai lava ia matou i le **1-800-805-2739** (TTY **711**). O le fesoasoani atu se tasi e tautala Gagana Samoa. E le totogia lea auaunaga.

Laotian:
ພວກເຮົາມີບໍລິການລ່າມແປພາສາຟຣີເພື່ອຕອບຄຳຖາມຕ່າງໆທີ່ທ່ານອາດຈະມີກ່ຽວກັບແຜນສຸຂະພາບ ຫຼື ແຜນຢາຂອງພວກເຮົາ. ເພື່ອຂໍລ່າມແປພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ **1-800-805-2739** (TTY **711**). ຄົນທີ່ເວົ້າ ພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ເປັນບໍລິການຟຣີ.

Bisayan: Duna mi’y libreng serbisyo sa tig-interpret aron motubag sa bisan unsa nimong mga pangutana mahitungod sa imong panglawas o plan sa tambal. Aron mokuha og tig-interpret, tawagi lang mi sa **1-800-805-2739** (TTY **711**). Ang usa ka tawo nga nagsulti og Pinulongan makatabang kanimo. Kini usa ka libreng serbisyo.

Marshallese: Ewor ad jerbal in ukok ko ñan uak jabdewōt kajitok emaroñ in wōt am ikijen būlāān in ājmour ako uno ko rekajur. Ñan bukot juon riukok, kurtok kij ilo **1-1-800-805-2739** (TTY **711**). Juon armij ej kajiton Kajin eo ñan jibañ eok. Ejelok onean jerbal in.

Hawaiian: Inā kekahi mau nīnau nāu e pili ana i kā mākou papahana ʻinikua mālama olakino a i ʻole ka ʻinikua lāʻau kuhikuhi, loaʻa ia pū ke kōkua unuhi manuahi i ka ʻōlelo Hawaiʻi. Inā makemake ʻoe i kēia kōkua, e ʻoluʻolu ke kelepona mai iā mākou i ka helu **1-800-805-2739** (TTY **711**). no ka walaʻau ʻana e pili ana i kēia mau papahana i ka ʻōlelo Hawaiʻi. Eia la ke kōkua manuahi.

Chuukese: Mi kawor aninisin chiaku ika awewen kapas ika epwe wor omw kapas eis fan iten ach kei okot ren pekin manaw me sefei. Ika ke mochen nóunóu emon chon chiaku, kopwe kori kich ren en namba **1-800-805-2739** (TTY **711**). Emon aramas mi sine Chuuk mi tongeni anisuk. Ei aninis ese kamo.