



Prescription Drug Program



This is your 2009 Evidence of Coverage (EOC)

Your Medicare Prescription Drug Coverage as a Member of TEAMStar Medicare Part D Prescription Drug Coverage

This booklet gives the details about your Medicare prescription drug coverage from **January 1 - December 31, 2009**, and explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

TEAMStar Medicare Part D Customer Service:

For help or information, please call Customer Service or go to our Plan website at www.teamstarpartd.com.

Calls to these numbers are free:

Claims Questions:	1-800-797-9791
Other Customer Service:	1-866-524-4173
TTY/TDD:	1-866-524-4174

Hours of Operation: 8:00am to 8:00pm EST/EDT.

This Plan is offered by the International Brotherhood of Teamsters Voluntary Employees Benefits Trust, referred to throughout the EOC as "we," "us," or "our." TEAMStar Medicare Part D is referred to as "Plan" or "our Plan." Our Plan is administered by United American Insurance Company. Our organization contracts with the Federal government.

Esta información está disponible en Español. Llame por favor al servicio de atención al cliente en el número enumerado arriba si usted necesita la información del plan en Español.

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Section 1: Introduction

Thank you for being a member of TEAMStar Medicare Part D Prescription Drug Coverage!

We are pleased that you've chosen our Plan – TEAMStar Medicare Part D.

This is your Evidence of Coverage, which explains how to get your Medicare drug coverage through our Plan, a Prescription Drug Plan (PDP).

Thank you for your membership in TEAMStar Medicare Part D; you are getting your Medicare prescription drug coverage through our Plan. TEAMStar Part D is not a "Medigap" Medicare Supplement Policy.

This Evidence of Coverage, together with your enrollment, Summary of Benefits, riders, formulary, and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009, - December 31, 2009. Our Plan's contract with the Centers for Medicare and Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get your prescriptions filled including some rules you must follow.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage.

This section of the EOC has important information about:

- Eligibility requirements
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

Eligibility Requirements

To be a member of our Plan, you must either be entitled to Medicare Part A, or enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this Plan.

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. Pharmacists and others use your membership record to know what drugs are covered for you. Section 3 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by telling Customer Service if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

Now that you are a member of our Plan, you must use our membership card for prescription drug coverage at network pharmacies. You may need to continue to use your red, white, and blue Medicare card to get covered services and items under Original Medicare.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered prescription drugs. If your membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

There is a sample card in Section 10 to show you what it looks like.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a regional Pharmacy Directory, which gives you a list of our network pharmacies in your area, at least every three years, and an update of our Pharmacy Directory every year that we don't send you a regional Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions that have been filled previously;
- A summary of your coverage this year, including information about:
 - o **Amount Paid For Prescriptions** - The amounts paid that count towards your initial coverage limit – if your plan has an initial coverage limit.
 - o **Total Out-Of-Pocket Costs That Count Toward Catastrophic Coverage** - The total amount you and/or others have spent on prescription drugs that count towards your qualifying for catastrophic coverage. This total includes the amounts spent for your co-payment or coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit, if any. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly plan premium

The monthly Plan premium amount paid by or through your Group for you does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information).

If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you may not have to pay for all or part of your share of the monthly premium. If you have questions about the monthly premium, call your Group Benefits Administrator.

Your monthly plan premium

The monthly premium amount described in this section does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information).

As a member of TEAMStar Medicare Part D, you pay a monthly plan premium. (If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you may not have to pay for all or part of the monthly premium.)

Your monthly premium for our Plan is listed in Section 10.

If you get benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your monthly plan premium.

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP at the phone number listed in Section 8 to determine what benefits are available to you.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium.

Pay your plan premium directly to our Plan by check.

You may decide to pay your premium directly to our Plan with a check or money order.

For your convenience, we will provide premium statements approximately 10 days prior to the date each premium is due. Simply mail the return portion of each statement with your check made payable to United American Insurance Company, P.O. Box 268862, Oklahoma City, OK 73126-8862. Envelopes for mailing are provided with each statement. Premiums can be paid monthly, quarterly, semi-annually or annually for the 2009 plan year. Payments must be received by the 5th of the month to be reflected on the next month's statement.

Instead of paying by check, you can have your premium automatically withdrawn via electronic funds transfer on a monthly basis from your bank account on the date you choose. If you did not choose this option at the time of your enrollment, you may still choose this method. Just complete the bank draft authorization form found in your billing notice from us, or you can contact Customer Service and they will send you a form.

Can your monthly plan premiums change during the year?

The monthly plan premium associated with this Plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose, extra help for your prescription drug costs. If our monthly Plan premium changes for next year, we will tell you in October and the change will take effect on January 1.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify for extra help, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2008, the national base beneficiary premium is \$27.93. This amount may change in 2009). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Customer Service to find out more about the reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable prescription drug coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help

What extra help is available to help pay my plan costs?

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 will get help paying for your Medicare drug plan's monthly premium and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails a letter to people who automatically qualify for extra help.

- 2 **You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than \$15,600 (single with no dependents) or \$21,000 (married and living with your spouse with no dependents), and your resources are less than \$11,990 (single) or \$23,970 (married and living with your spouse). These resources include \$1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. **If you think you may qualify, call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office.** After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

If you qualify for extra help, we will send you by mail an “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs” that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs”.

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us. Please contact Customer Service for specific instructions.

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

Important Information

We will send you a Coordination of Benefits (COB) Survey so that we can know what other drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional drug coverage, you are required to provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional prescription drug coverage, please call Customer Service to update your membership records.

Section 2: How You Get Prescription Drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 10.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your premiums and/or cost-sharing. Please contact your SPAP to determine what benefits are available to you. SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of healthcare providers. Both brand name drugs and generic drugs are included on the formulary. A generic drug is 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, generic drugs cost less than brand name drugs.

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 10 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our website. You may also call Customer Service to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or co-payment depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 5 to learn more about how to request an exception.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that

the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug isn't on the formulary?

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly (if there is a change). In addition, you may contact Customer Service to be sure it isn't covered. If Customer Service confirms that we don't cover your drug, you have two options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service or go to our formulary on our website.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the Plan's denial. See Section 5 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 5 under "What is an exception?" to learn more about how to request an exception. Please contact Customer Service if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year and provide you with the opportunity to request a formulary exception in advance for the following year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long term care facility (like a nursing home) and been with the Plan 90 days or less, we will cover a temporary 3x 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access. See Section 10 for information about non-Part D drugs.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. This may be in addition to a standard one month or three month supply.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, or by calling Customer Service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 5 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan doesn't affect Medicare 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, it can't be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this Plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B. The *Medicare & You* handbook can also be found on www.medicare.gov or you can request a copy by 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and whether the prescription drug coverage you have is creditable (whether it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you have other prescription drug coverage

If you currently have other prescription drug coverage that is not a Medicare Part D Plan through another employer or retiree group, please contact that group to determine how your other prescription drug coverage will work with this Plan. The Part D prescription drug coverage you get from us may be secondary to your other drug coverage.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?"; **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Customer Service.

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call 1-800-797-9791 to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail order pharmacy service?

You may use our network mail order pharmacy service to fill prescriptions for "maintenance drugs." These are drugs that you take on a regular basis for a chronic or long-term medical condition.

When you order prescription drugs through our network mail order pharmacy service, you must order a 90 day supply of the drug.

For a new prescription order, it generally takes us up to 10-12 business days to process your order and ship it to you. For a refill order, it generally takes up to 6 business days to process your order and ship it to you. However, sometimes your mail order may be delayed. Make sure you have at least a 14-day supply of that medication on hand. If your mail order shipment is delayed, please call 1-800-797-9791 (TTY/TDD users should call 1-866-524-4174). The customer service representative will work with you to acquire a supply of your prescription at your convenience. The customer service representative can contact the prescribing physician for an emergency supply, as well as the pharmacy of your choice, and will provide assistance in resolving utilization management rejections that may occur. We'll make sure you have your medication when you need it.

You are not required to use mail order prescription drug services to obtain an extended supply of maintenance medications. Instead, you have the option of using another network retail pharmacy in our network to obtain a supply of maintenance medications. Some of these retail pharmacies may agree to accept the mail order cost-sharing amount for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may not agree to accept the mail order cost-sharing amounts for an extended supply of medications. In this case, you will be responsible for the difference in price. Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of medications. You can also call Customer Service for more information.

To get order forms and information about filling your prescriptions by mail, visit our website or contact Customer Service. Please note that you must use our network mail order service. Prescription drugs that you get through any other mail order services are not covered.

How do you fill prescriptions outside the network?

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your coinsurance or co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called “How do you submit a paper claim?” If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

Other times you can get your prescriptions covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- 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.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and some covered drugs that are administered in your doctor’s office.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above (“How do you fill prescriptions outside the network?”), 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 and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs paid for in full when you don’t have your membership card.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because you don’t have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs purchased at a better cash price.** In rare circumstances when you are in a coverage gap period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan’s benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.
- **Copayments for drugs provided under a drug manufacturer patient assistance program.** If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our Plan’s benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Customer Service. **Please include your receipt(s) with your written request.**

Please send your written reimbursement request to the address listed under Part D Coverage Determinations in Section 8.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, and they aren't covered by Medicare Part A or Part B.) We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After Medicare Part A stops paying for your prescription drug costs as part of Medicare-covered skilled nursing facility stay, we will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network and the drugs aren't otherwise covered by Medicare Part A or Part B). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a Medicare Advantage Plan, new Prescription Drug Plan, or the Original Medicare Plan. See Section 6 for more information about leaving this Plan and joining a new Medicare Plan.

Long term care (LTC) pharmacies

Generally, residents of a long term care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Customer Service.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through our Plan's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies). Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, contact Customer Service.

Home infusion pharmacies

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature and aren't already covered by Medicare Part B. This coverage includes the cost of vaccine administration. See Section 10 for more information about your costs for covered vaccinations.

Section 3: Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged 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 review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service.

You have the right to timely access to your prescriptions at any network pharmacy

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to 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 have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. 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. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your State Department of Health.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Customer Service.

Your right to get information in other formats

You have the right to get your questions answered. Our Plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your Plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network pharmacies

You have the right to get information from us about our network pharmacies. To get this information, call Customer Service.

Your right to get information about your prescription drugs and costs

You have the right to an explanation from us about any prescription drugs not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug, and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug from a pharmacy not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary website or call Customer Service for more information.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage. See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Customer Service at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service if you have questions.
- Using all of your insurance coverage. If you have additional prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the drug benefits that are available to you.
- **You are required to tell our Plan if you have additional drug coverage. Call Customer Service.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Paying your plan premiums and coinsurance or co-payment for your covered services. You must pay for services that aren't covered.
- Notifying us if you move.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service.

Section 4: How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs.

If we will not pay for or give you the Part D drugs you want, you must follow the rules outlined in Section 5.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Customer Service.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a “fast” decision or a “fast” appeal. We discuss these fast decisions and appeals in Section 5.
- We don’t give you a decision within the required time frame.
- We don’t give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don’t forward your case to the Independent Review Entity if we do not give you a decision on time.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.”

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your “representative.” You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for Part D Grievances (for complaints about Part D drugs) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this formal procedure TEAMStar Medicare Part D’s Grievance Review. When your grievance cannot be resolved by phone, you should write to TEAMStar Medicare Part D Grievance Review, P.O. Box 6106, Cypress, CA 90630-9948, MS CA 124-0197. Your letter should state the nature of the grievance including the name of the person or pharmacy with whom you have a grievance and the date of the occurrence, or other details as appropriate.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a “fast grievance,” meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

Section 5: Complaints and Appeals about your Part D Prescription Drug(s)

Introduction

This section explains how you ask for coverage of your Part D drug(s) or payments in different situations. These types of requests and complaints are discussed below in Part 1.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs. For more information about grievances, see Section 4.

PART 1. Requests for Part D drugs

This part explains what you can do if you have problems getting the Part D drugs you request, or payment (including the amount you paid) for a Part D drug you already received.

If you have problems getting the Part D drugs you need, or payment for a Part D drug you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug you need, or paying for a Part D drug you already received. Initial decisions about Part D drugs are called “coverage determinations.” With this decision, we explain whether we will provide the Part D drug you are requesting, or pay for the Part D drug you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.
- You ask for a Part D drug that is not on your plan sponsor’s list of covered drugs (called a “formulary”). This is a request for a “formulary exception.” **See “What is an exception?” below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools – such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. **See “What is an exception?” below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a “tiering exception.” **See “What is an exception?” below for more information about the exceptions process.**
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician’s office, will be covered by the Plan. See “Filling Prescriptions Outside of Network” in Section 2 for a description of these circumstances.

What is an exception?

An exception is a type of initial determination (also called a “coverage determination”) involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan.
- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more. *See Section 2 (“Utilization Management”) to learn more about our additional coverage restrictions or limits on certain drugs.*
- You may ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier (Tier 3), you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier (Tier 2) instead. This would lower the co-payment or coinsurance amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Brand tier (Tier 4).

Generally, we will only approve your request for an exception if the alternative drugs included on the Plan formulary or the drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number shown under **Part D Coverage Determinations** in Section 8 to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your “appointed representative.” You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under “**Part D Coverage Determinations.**” To learn how to name your appointed representative, you may call Customer Service.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a “standard” or “fast” initial determination

A decision about whether we will give you, or pay for, the Part D drug you are requesting can be a “standard” decision that is made within the standard time frame, or it can be a “fast” decision that is made more quickly. A fast decision is also called an “expedited” decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) in Section 8. .

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part D drug that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** for appeals about Part D drugs in Section 8. .

Be sure to ask for a “fast,” or “expedited” review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “fast grievance.” You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).
Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as prior authorization, dosage limits, quantity limits, or step therapy requirements), we must give you our decision no later than 72 hours after we receive your physician’s “supporting statement” explaining why the drug you are asking for is medically necessary.
If you have not received an answer from us within 72 hours after we receive your request (or your physician’s supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.
- For a fast initial determination about a Part D drug that you have not yet received.

If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- For a fast decision about a Part D drug that you have not yet received.

We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. **(See Appeal Level 1.)**

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan "**redetermination.**" When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part D drug a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8. You may also ask for a standard appeal by calling us at the phone number shown under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4).

If we deny your request for a fast appeal, we will give you a standard appeal. While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Appeal requests should be sent to TEAMStar Part D Appeal and Grievance Department, P.O. Box 6106, Cypress, CA 90630-9948, MS CA 124-0197.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

You may also deliver additional information in person to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet received.

We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- For a fast decision about a Part D drug that you have not yet received.

We must cover the Part D drug you requested no later than 72 hours after we receive your request.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity. We are allowed to charge you a fee for copying and sending this information to you.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

Section 6 Ending your Membership

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.
- There are also limited situations where we are required to end your membership. For example, if you do not stay continuously enrolled in Medicare Part A or B (or both)..

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the “Annual Election Period”), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those who are part of a Group, those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table at the end of this section.

During the fall open enrollment period, if you want to end your membership in our plan, this is what you need to do:

- **If you are planning on joining another Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- **If you are planning on enrolling in a Medicare Advantage plan:** Request enrollment in the new plan. In most cases, you will be disenrolled automatically when your new plan’s coverage begins on January 1.
EXCEPTION -- If you are joining a Medicare Advantage “Private Fee-for-Service” plan and that plan does not offer drug coverage, or a Medicare Medical Savings Account (MSA) Plan, enrollment will not automatically disenroll you from our plan. Therefore, you will need to do the following:
 - o To join a new Medicare prescription drug plan, simply join the new Medicare prescription drug plan, or
 - o If you do not want Medicare prescription drug coverage, find out how to request disenrollment from our plan by contacting Customer Service. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048.
- **If you would like to end your membership without joining any other Medicare health or prescription drug plan:** Contact your Group Benefits Administrator or our Customer Service to find out how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

IMPORTANT -- If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage (coverage that is at least as good as Medicare drug coverage), you may have to pay a penalty if you join later.

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage. Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request
Special Enrollment Periods for limited special exceptions, such as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the “*Medicare & You*” handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov - under “Search Tools,” select “Find a Medicare Publication.”

Until your membership ends, you must keep getting your Medicare prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan’s network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy including our mail order pharmacy service listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A or B (or both).
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 60 day grace period during which you must pay the Plan premiums before your membership ends.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

Section 7: Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for prescription drugs or payment for prescription drugs you already received. For example, you may ask for an appeal if our Plan doesn't pay for a drug you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

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

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when drugs are received. It 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 "co-payment" amounts that a plan may require be paid when specific drugs are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug.

Coverage Determination –A decision from your Medicare drug plan 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 if you disagree.

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

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. There is a separate department and phone number for questions about claims and drugs. See Section 8 for information about how to contact Customer Service.

Deductible – If applicable to your Plan, the amount you must pay for the drugs you receive before our Plan begins to pay its share of your covered drugs. Our Plans do not have a deductible.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

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

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

Formulary – A list of covered drugs provided by the Plan.

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, generic drugs cost less than brand name drugs.

Grievance - A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period before your total drug expenses have reached \$2,700, including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

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 (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plans in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

Medicare 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 the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

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

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

Original Medicare Plan – (“Traditional Medicare” or “Fee-for-service” Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn’t have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see “Medicare Advantage (MA) Plan”

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

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 10 for a listing of these drugs). These drugs are not considered Part D drugs.

Prior authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

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

Service area – “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration 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.

Section 8: Helpful Phone Numbers and Resources

Contact Information for our Plan's Customer Service

If you have any questions or concerns, please call or write to our Plan Customer Service. We will be happy to help you.

CALL	1-866-524-4173, 8:00am to 8:00pm EST/EDT. Calls to this number are free.
TTY/TDD	1-866-524-4174. This number requires special telephone equipment. Calls to this number are free.
FAX	1-972-569-3709
WRITE	TEAMStar Part D Customer Service, c/o United American Insurance Company, P.O. Box 8080, McKinney, TX 75070
VISIT	TEAMStar Medicare Part D c/o United American Insurance Company 3700 S. Stonebridge Drive McKinney, TX 75070
WEBSITE	www.teamstarpartd.com

Contact Information for Grievances, Coverage Determinations and Appeals

Part D Coverage Determinations

CALL	1-800-797-9791. Calls to this number are free.
TTY/TDD	1-866-524-4174. This number requires special telephone equipment. Calls to this number are free.
FAX	Standard Redetermination 1-866-308-6294 Expedited Redetermination 1-866-308-6296
WRITE	TEAMStar Part D Appeal and Grievance Department P.O. Box 6106 Cypress, CA 90630-9948 MS CA124-0197

For information about Part D coverage determinations, see Section 5.

Part D Grievances

CALL	1-866-524-4173. Calls to this number are free. If you are requesting a decision outside of normal business hours, be sure to call us at 1-800-797-9791 and listen to the recording for further instructions.
TTY/TDD	1-866-524-4174. This number requires special telephone equipment. Calls to this number are free.
FAX	1-866-308-6294
WRITE	TEAMStar Part D Appeal and Grievance Department P.O. Box 6106 Cypress, CA 90630-9948 MS CA124-0197

For information about Part D grievances, see Section 4.

Part D Appeals

CALL	1-800-797-9791. Calls to this number are free.
TTY/TDD	1-866-524-4174. This number requires special telephone equipment. Calls to this number are free.
FAX	1-866-308-6294
WRITE	TEAMStar Part D Appeal and Grievance Department P.O. Box 6106 Cypress, CA 90630-9948 MS CA124-0197

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You Handbook*, visit www.medicare.gov and choose “Find Helpful Phone Numbers and Resources,” or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

State Health Insurance Assistance Program (SHIP)

SHIPs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact the SHIP in your state – *please see Section 11 for how to contact the SHIP in your state*. You may also find the website for your local SHIP at www.medicare.gov on the Web. Under “Search Tools,” select “Helpful Phone Numbers and websites.”

Quality Improvement Organization

“QIO” stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

Please refer to Section 11 for how to contact the QIO in your state.

How to contact the Medicare program

Medicare is 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). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government website for Medicare information. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under “Search Tools” for Medicare contacts in your state. Select “Helpful Phone Numbers and websites.” 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.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. *To find out more about Medicaid and its programs, refer to Section 11 to contact your state Medicaid agency.*

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

State Pharmacy Assistance Program (SPAP)

SPAPs are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. *Refer to Section 11 for information to contact your state's SPAP.*

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you or your spouse get your benefits from your current or former employer or union, or from your spouse's current or former employer or union, call your employer's or union's benefits administrator or Customer Service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Customer Service to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Section 9: Legal Notices

Notice about governing law

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

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. 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, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Section 10: How Much You Pay for Your Part D Prescription Drugs

Your Monthly Premium for Our Plan

As a member of TEAMStar Medicare Part D you must pay a monthly plan premium, unless you qualify for extra help from Medicare.

The table below shows the monthly premium amounts:

States	SILVER Monthly Premium	PLATINUM Monthly Premium
All 50 states and D.C.	\$30**	\$85**

**** Monthly premiums will be reduced to \$29 for the Silver plan and \$84 for the Platinum plan if you elect to pay premiums by monthly bank draft.**

Note: Monthly premiums shown do not reflect any Medicare imposed penalties for late enrollment.

If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs." You can also get that information by calling Customer Service. If you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your monthly plan premiums. Please contact your SPAP to determine what benefits are available to you. Note that there is not an SPAP in every state, and in some states the SPAP has another name. See Section 8. You can find more information about paying your plan premium in Section 1.

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Later in this section under "General Exclusions" you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Customer Service to request one.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on your Plan, the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described in your Summary of Benefits. Refer to your plan formulary to see what drugs we cover and what tier they are on. Refer to your Summary of Benefits for specific information about your Plan. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described in your Summary of Benefits. For more information, see the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs." If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 1 for more information.

Initial Coverage Period

During the initial coverage period, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the coinsurance or co-payment. Your coinsurance or copayment will vary depending on the drug and where the prescription is filled. There is no deductible.

You will pay the following for your covered prescription drugs:

DRUG TYPE	SILVER		PLATINUM	
	RETAIL 30-Day Supply Co-pay	MAIL 90-Day Supply Co-pay	RETAIL 30-Day Supply Co-pay	MAIL 90-Day Supply Co-pay
Preferred Generics Tier 1	\$6	\$12	\$6	\$12
Preferred Brands Tier 2	\$26	\$52	\$20	\$40
Non-Preferred Brands and Generics Tier 3 and Tier 4	\$52	\$104	\$30	\$60

Once your total drug costs reach \$2,700, you will reach your Initial Coverage Limit. Your Initial Coverage Limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

Coverage after you reach your Initial Coverage Limit and before you qualify for Catastrophic Coverage (Coverage Gap)

Once your total calendar year drug costs (including both co-payments and plan payments) equal \$2,700 (the Initial Coverage Limit), your payments will depend on which plan you selected. With the Silver Plan you will pay 100% of your drug costs until your total calendar year out-of-pocket costs equal \$4,350. With the Platinum Plan, you pay a \$6 co-payment for preferred generics and 100% of your drug costs for all brands and non-preferred generics until your total calendar year out-of-pocket costs (including co-payments) equal \$4,350.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,350 out-of-pocket for the year. When the total amount you have paid toward coinsurance or co-payments and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of 5% coinsurance or \$2.40 for generics/preferred multisource drugs for generics or drugs that are treated like generics and \$6 for all other drugs for all other drugs. We will pay the rest.

Vaccine Coverage (including administration)

Our Plan's prescription drug benefit covers a number of vaccines, including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance/co-payment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember you are responsible for all of the costs associated with vaccines (including their administration) during a coverage gap phase of your benefit, if applicable.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or co-payment for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance/co-payment for the vaccine (including administration) less any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay your normal coinsurance/co-payment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine less any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

*If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Customer Service.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your annual deductible, if your Plan has one.
- Your coinsurance or co-payments up to the initial coverage limit.
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan
- Any payments you make for drugs in the coverage gap.

When you have spent a total of \$4,350 for items specified in your Plan, you will reach the catastrophic coverage level. Refer to your Summary of Benefits for specific details about your Plan.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;

- Qualified State Pharmacy Assistance Programs (SPAPs) (SPAPs have different names in different states. See Section 11 for the name and phone number for the SPAP in your area.)
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.

TEAM Star
MEDICARE PART D
Prescription Drug Program

Medicare Rx
Prescription Drug Coverage
CMS #E0654

Rx Bin 610097
 RxPCN 9999
 RxGrp PIB
 Issuer 80840
 ID # 12345678
 Paul C. Holder

Effective Date
 01-01-2009

E0654

MEMBERS: This card must be presented at a participating pharmacy when purchasing prescription drugs.

SUBMIT CLAIMS TO: Prescription Solutions
 P.O. Box 6083
 Cypress, CA 90630

IMPORTANT NUMBERS
Claims Questions: 1-800-797-9791
Other Customer Service: 1-866-524-4173
 TTY/TDD Line: 1-866-524-4174
 Provider Line: 1-800-797-9791
 www.teamstarpartd.com

E0654-F769

Excluded Drugs

This part of Section 10 talks about drugs that are “excluded,” meaning they aren’t normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 5).

- A Medicare Prescription Drug Plan can’t cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can’t cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug’s label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
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	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

If you receive extra help, 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.

Section 11: State Assistance Organizations

State Health Insurance Assistance Programs (SHIPs)

Alabama

AL Department of Senior Services
770 Washington Ave., Suite 470
PO Box 301851
Montgomery, AL 36130
Local: 1-334-242-5743
Tollfree: 1-800-243-5463
TTY: 1-334-242-0995
Fax: 1-334-242-5594
Hours: 8:00 am – 5:00 pm
www.ageline.net

Alaska

Alaska SeniorCare/Medicare Information and Referral Office
3601 C Street, Suite 310
Anchorage, AK 99503
Local: 1-907-269-3680
Tollfree: In-State Calls Only
1-800-478-6065
TTY: 1-907-269-3691
Fax: 1-907-269-3648
Hours: 8:00am – 4:00pm
www.seniorcare.alaska.gov

Arizona

Arizona State Health Insurance Assistance Program
1789 W. Jefferson St., #950a
Phoenix, AZ 85007
Tollfree: 1-800-432-4040
TTY: 1-602-542-6366
Fax: 1-602-542-6595
Hours: 8:00 am – 5:00 pm
www.azdes.gov/aaa

Arkansas

State Health Insurance Assistance Program of Arkansas
1200 W 3rd Street
Little Rock, AR 72201-1904
Local: 1-501-371-2782
Tollfree: 1-800-224-6330
Fax: 1-501-371-2781
Hours: 8:00 am – 4:30 pm
insurance.arkansas.gov/seniors/homepage.htm

California

Health Insurance Counseling and Advocacy Program (HICAP) of CA
1600 K St.
Sacramento, CA 95814
Tollfree: In-State Calls Only
1-800-434-0222
Hours: 8:00am- 4:00pm
www.aging.ca.gov

Colorado

Colorado State Health Insurance Assistance Program
1560 Broadway, Suite 850
Denver, CO 80202
Local: 1-303-894-7552
Tollfree: 1-888-696-7213
TTY: 1-303-894-7880
Spanish: 1-866-665-9668
Fax: 1-303-894-7455
Hours: 9:00 am – 4:00 pm
www.coloradomedicare.com

Connecticut

CHOICES
25 Sigourney St, 10th Floor
Hartford, CT 06106
Local: 1-860-424-5862
Tollfree: In-State Calls Only
1-800-994-9422
TTY: 1-860-842-5424
Fax: 1-860-424-4966
Hours: 8:00 am – 4:30 pm
www.ctelderlyservices.state.ct.us

Delaware

ElderInfo
841 Silverlake Blvd.
Dover, DE 19904
Local: 1-302-739-6266
Tollfree: In-State Calls Only
1-800-336-9500
Fax: 1-302-739-5280
Hours: 8:00 am – 4:30 pm
www.state.de.us/inscom/departments/elder/eldindex.shtml

District of Columbia

Washington, D.C. Health Insurance Counseling Project (HICAP)
2136 Pennsylvania Avenue NW
Washington, DC 20052
Local: 1-202-739-0668
TTY: 1-202-973-1079
Spanish: 1-202-739-0668
Fax: 1-202-293-4043
Hours: 9:00 am – 5:00 pm

Florida

SHINE - Serving Health Insurance Needs of Elders
4040 Esplanade Way, Bldg. B, Ste.260
Tallahassee, FL 32399
Local: 1-850-414-2060
Tollfree: 1-800-963-5337
TTY: 1-850-414-2001
Fax: 1-850-414-2002
Hours: 8:00 am – 5:00 pm
www.FloridaShine.org

Georgia

Georgia Cares
2 Peachtree Street, NW, Suite 9-230
Atlanta, GA 30303
Local: 1-404-657-5334
Tollfree: 1-800-669-8387
Fax: 1-404-657-1727
Hours: 8 am – 5 pm
www.dhr.georgia.gov

Hawaii

PLUS
250 South Hotel St., Suite 406
Honolulu, HI 96813
Local: 1-808-586-7299
Tollfree: 1-888-875-9229
Fax: 1-808-586-0185
Hours: 8:00 am – 5:00 pm
www4.hawaii.gov/eoa/programssage_plus

Idaho

Senior Health Insurance Benefits Advisors of Idaho (SHIBA)

700 West State St., 3rd Floor
Boise, ID 83720-0043
Tollfree: In-State Calls Only
1-800-247-4422
Fax: 1-208-334-4389
Hours: 8:00 am - 5:00 pm
www.doi.idaho.gov

Illinois

Senior Health Insurance Program of Illinois (SHIP)

320 W Washington St.
Springfield, IL 62767
Local: 1-217-785-9021
Tollfree: 1-800-548-9034
TTY: 1-217-524-4872
Fax: 1-217-782-4105
Hours: 8:00 am - 5:00 pm
www.idfpr@illinois.gov

Indiana

Indiana Senior Health Insurance Information Program (SHIP)

311 W. Washington, Suite 300
Indianapolis, IN 46204-2781
Tollfree: 1-800-452-4800
Fax: 1-317-233-3475
Hours: 8:00 am - 7:00pm
www.medicare.in.gov

Iowa

Senior Health Insurance Information Program of Iowa (SHIP)

330 Maple
Des Moines, IA 50319-0065
Local: 1-515-281-5705
Tollfree: 1-800-351-4664
Fax: 1-515-281-3059
Hours: 8:00 am - 4:00 pm
www.shiip.state.ia.us/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)

503 S. Kansas
Topeka, KS 66603
Local: 1-316-337-7386
Tollfree: 1-800-860-5260
Fax: 1-785-296-0256
Hours: 8:00 am - 5:00 pm
www.agingkansas.org/shick/shick_index.html

Kentucky

Kentucky State Health Insurance Assistance Program

275 E. Main St., 5W-A
Frankfort, KY 40621
Tollfree: 1-877-293-7447
Fax: 1-502-564-4595
Hours: 8:00 am - 4:30 pm
chfs.ky.gov/dhss/das/ship.htm

Louisiana

Louisiana Senior Health Insurance Information Program (SHIP)

PO Box 94214
Baton Rouge, LA 70804-9214
Local: 1-225-342-5301
Tollfree: In-State Calls Only
1-800-259-5301
Fax: 1-225-342-5301
Hours: 8:00 am - 4:30 pm
www.lidi.state.la.us

Maine

Maine State Health Insurance Assistance Program (SHIP)

11 State House Station
442 Civic Center Drive
Augusta, ME 04333-2723
Local: 1-207-621-0087
Tollfree: In-State Calls Only
1-877-353-3771
Fax: 1-207-287-9234
Hours: 9:00AM-5:00PM Fri 9-4
www.maine.gov/dhhs/beas/

Maryland

Maryland Senior Health Insurance Assistance Program

301 West Preston St., Room 1007
State Office Building
Baltimore, MD 21201
Local: 1-410-767-1100
Tollfree: In-State Calls Only
1-800-243-3425
TTY: 1-410-767-1083
Fax: 1-410-333-7943
Hours: hrs. 8:30 a.m.-5:30p.m.
www.mdoa.state.md.us/ship.html

Massachusetts

Serving Health Information Needs of Elders (SHINE)

1 Ashburton Place, 5th Floor
Boston, MA 02108
Tollfree: 1-800-243-4636
Fax: 1-617-727-9368
Hours: 9:00 am - 5:00 pm (M-F)
www.mass.gov/elders

Michigan

Medicare/Medicaid Assistance Program of Michigan (MMAP)

6105 W St. Joseph, Suite 209
Lansing, MI 48917
Local: 1-517-886-1242
Tollfree: 1-800-803-7174
Fax: 1-517-373-1305
Hours: 8:00 am - 5:00 pm
www.mymmap.org

Minnesota

Minnesota SHIP/Senior LinkAge Line

444 Lafayette Rd
Saint Paul, MN 55155
Tollfree: 1-800-333-2433
Fax: 1-651-297-7855
Hours: 8AM-4PM (CST)
www.mnaging.org/

Mississippi

Mississippi Insurance Counseling and Assistance Program (MICAP)

750 N. State Street
Jackson, MS 39202
Local: 1-601-359-4929
Tollfree: 1-800-948-3090
Fax: 1-601-359-9664
Hours: 8:00 am - 5:00 pm
www.mdhs.state.ms.us/

Missouri

CLAIM Program of Missouri (SHIP)

3425 Constitution Ct., Suite E
Jefferson City, MO 65109
Local: 1-573-817-8320
Fax: 1-573-893-5827
Hours: 9:00 to 4:00 pm
www.missouryclaim.org

Montana

Senior and Long Term Care Division of Montana Office on Aging

111 North Sanders St., PO Box 4210
Room 210
Helena, MT 59604
Local: 1-406-444-7870
Tollfree: In-State Calls Only
1-800-551-3191
Fax: 1-406-444-7743
Hours: 8:00 am – 5:00 pm
www.dphhs.mt.gov/sltc/index.shtml

Nebraska

Nebraska State Health Insurance Information Program (SHIIP)

941 O Street, Suite 400
Lincoln, NE 68508
Local: 1-402-471-2201
Tollfree: 1-800-234-7119
Fax: 1-402-471-6559
Hours: 9:00 am – 4:00 pm
www.doi.ne.gov/shiip

Nevada

State Health Insurance Advisory Program of Nevada

Local: 1-702-486-3478
Tollfree: 1-800-307-4444
Spanish: 1-702-386-8554
Fax: 1-702-486-3572
Hours: 8:00 am – 4:00 pm
www.nvaging.net

New Hampshire

Health Insurance Counseling Education and Assistance Services

79 Sheep Davis Road
PO Box 2338
Concord, NH 03302
Local: 1-603-225-9000
Tollfree: In-State Calls Only
1-800-852-3388
Fax: 1-603-225-4033
Hours: 8am-8pm
www.hiceas.org

New Jersey

New Jersey Department of Health and Senior Svc. PO Box 807

Trenton, NJ 08625-0807
Local: 1-877-222-3737
Tollfree: In-State Calls Only
1-800-792-8820
Fax: 1-609-588-3601
Hours: 8:30 am – 5:00 pm
www.state.nj.us/health

Section 11

New Mexico

Benefits Counseling Program NM Aging and Long-Term Service Dept.

2550 Cerrillos Road
Santa Fe, NM 87505
Local: 1-505-476-4799
Tollfree: In-State Calls Only
1-800-432-2080
Fax: 1-505-222-4526
Hours: 8:30 am – 4:30 pm
www.nmaging.state.nm.us/

New York

Health Insurance Information Counseling and Assistance Program

2 Empire State Plaza, Agency Bldg. #2
New York City, NY 12223
Tollfree: 1-800-701-0501
Fax: 1-518-486-2225
Hours: 9:00 am – 3:00 pm (M-F)
www.hiicap.state.ny.us/

North Carolina

North Carolina Senior Health Insurance Information Program

111 Seaboard Ave.
Raleigh, NC 27604
Local: 1-919-807-6900
Tollfree: In-State Calls Only
1-800-443-9354
Hours: 8:00 am – 5:00 pm
www.ncshiiip.com/

North Dakota

North Dakota Insurance Department

State Capitol, 600 East Blvd., 5th Floor
Bismarck, ND 58505
Local: 1-701-328-2440
Tollfree: 1-888-575-6611
Fax: 1-701-328-9610
Hours: 7:30 am – 5:00 pm
www.state.nd.us/ndins

Ohio

Senior Health Insurance Information Program of Ohio (SHIP)

2100 Stella Court
Columbus, OH 43215-1067
Local: 1-614-644-3458
Tollfree: 1-800-686-1578
Fax: 1-614-752-0740
Hours: 7:30 am – 5:00 pm
www.ohioinsurance.gov/

Oklahoma

Oklahoma Senior Health Insurance Counseling Program (SHICP)

2401 NW 23rd St, Suite 28
Oklahoma City, OK 73107
Local: 1-405-521-6628
Tollfree: In-State Calls Only
1-800-763-2828
Fax: 1-405-522-4492
Hours: 8:00 am – 5:00 pm
www.oid.state.ok.us

Oregon

Oregon Senior Health Insurance Benefits Assistance (SHIBA)

PO Box 14480
Salem, OR 97309-0405
Local: 1-503-378-2014
Tollfree: In-State Calls Only
1-800-722-4134
TTY: 1-503-947-7280
Fax: 1-503-378-8365
Hours: 8:00-5:00 PST
oregonshiba.org/

Pennsylvania

APPRISE

555 Walnut Street, 5th Floor
Harrisburg, PA 17101
Local: 1-717-783-8975
Tollfree: 1-800-783-7067
Fax: 1-717-772-3382
Hours: 9:00am – 4:00 pm
www.aging.state.pa.us

Rhode Island

Rhode Island Senior Health Insurance Program (SHIP)

Benjamin Rush Bldg, #55
35 Howard Ave.
Cranston, RI 02920
Local: 1-401-462-4444
TTY: 1-401-462-0740
Fax: 1-401-277-2130
Hours: 8:30 am – 4:00 pm
www.dea.ri.gov

South Carolina

Bureau of Senior Services of SC

Jefferson Square Bldg, PO Box 8206
Columbia, SC 29202-8206
Local: 1-803-734-9900
Tollfree: 1-800-868-9095
Fax: 1-803-734-9887
Hours: 8:30 am – 5:00 pm
www.aging.sc.gov

South Dakota

Adult Services and Aging of SD

700 Governor's Drive
Pierre, SD 57501
Local: 1-605-773-3656
Tollfree: 1-800-536-8197
TTY: 1-605-367-5760
Fax: 1-605-336-7471
Hours: 8:00 am - 5:00 pm CT
www.shiine.net

Tennessee

TN Commission on Aging and Disability

2670 Union Ave
10th Fl. Suite 1000
Memphis, TN 38112
Tollfree: 1-877-801-0044
TTY: 1-615-532-3893
Fax: 1-615-741-3309
Hours: 8:00 am - 4:30 pm
www.state.tn.us/comaging/ship

Texas

Dept. of Aging and Disabilities Services

4900 N Lamar, 4th Floor
Austin, TX 78751
Tollfree: 1-800-252-9240
Fax: 1-512-438-3538
Hours: 8AM-5PM
www.dads.state.tx.us

Utah

Aging and Adult Services of Utah

120 North 200 West, Suite 325
Salt Lake City, UT 84103
Local: 1-801-538-3910
Tollfree: 1-800-541-7735
Fax: 1-801-538-4395
Hours: 8:00 am - 5:00 pm
www.daas.utah.gov/hiip_contact_list.htm

Vermont

Area Agency on Aging of Vermont

1161 Portland St
St. Johnsbury, VT 05819
Local: 1-802-748-5182
Tollfree: In-State Calls Only
1-800-642-5119
Fax: 1-802-748-6622
Hours: 8:30am-4:30pm ET M-F
www.medicarehelpvt.net/

Virginia

Virginia Insurance Counseling and Assistance Program (VICAP)

1600 Forest Ave, Ste 102
Richmond, VA 23229
Local: 1-804-662-9333
Tollfree: 1-800-552-3402
Fax: 1-804-662-9354
Hours: 8:30am-5pm
www.vda.virginia.gov

Washington

Statewide Health Insurance Benefits Advisors of Washington

PO Box 45600
Olympia, WA 98504
Local: 1-360-725-7073
Tollfree: 1-800-562-6900
TTY: 1-360-586-0241
Spanish: 1-800-562-6900
Hours: 8:00 am - 5:00 pm PST
www.insurance.wa.gov

West Virginia

Bureau of Senior Services of WV

1900 Kanawha Blvd, Bldg 10
Charleston, WV 25305
Local: 1-304-558-3317
Tollfree: 1-877-987-4463
Fax: 1-304-558-0004
Hours: 8:30am-5:00pm ET M-F
www.state.wv.us/seniorservices

Wisconsin

State Health Insurance Assistance Program of Wisconsin

214 N. Hamilton Street
Madison, WI 53703-2118
Tollfree: 1-800-242-1060
Spanish: 1-888-701-1255
Fax: 1-608-267-3203
Hours: 8:00 am - 4:30 pm
www.dhfs.state.wi.us/aging/SHIP.htm

Wyoming

State Health Insurance Information Program of Wyoming (SHIP)

122 W, 25th St., Hershler, 3rd Floor E
Cheyenne, WY 82002
Tollfree: 1-800-856-4398
Fax: 1-307-856-4466
Hours: 8:00 am - 5:00 pm
www.wyomingseniors.com

State Quality Improvement Organizations (QIOs)

Alabama

AL Quality Assurance Foundation
2 Perimeter Park South Suite 200 West
Birmingham, AL 35243
Local: 1-205-970-1600
Tollfree: 1-800-760-3540
Fax: 1-205-970-1624
Hours: 8:00 am - 4:30 pm
www.aqaf.com

Alaska

QualisHealth
721 Sesame Street, Suite 1A
Anchorage, AK 99503
Local: 1-907-562-2252
Tollfree: 1-800-878-7170
Hours: 8:00am-5:00pm
www.qualishealth.org

Arizona

Health Services Advisory Group
1600 E. Northern Ave, Ste. 100
Phoenix, AZ 85020-3933
Local: 1-602-264-6382
Tollfree: 1-800-359-9909
Fax: 1-602-241-0757
Hours: 8:00am - 5:00pm
www.hsag.com

Arkansas

Arkansas Foundation for Medical Care
2201 Brooken Hill Drive
Fort Smith, AR 72908
Local: 1-479-649-8501
Tollfree: 1-800-272-5528
Hours: 8:30am - 5:00pm
www.afmc.org

California

Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104
Local: 1-415-677-2000
Tollfree: 1-800-841-1602
Fax: 1-800-677-2185
Hours: 9:00am-5:00pm
www.lumetra.com

Colorado

Colorado Foundation for Medical Care
2851 South Parker Road, Suite 1000
Aurora, CO 80014
Local: 1-303-695-3300
Tollfree: 1-800-950-8250
TTY: 1-303-695-3314
Fax: 1-303-695-3377
Hours: 8:00 am - 5:00 pm
www.cfmc.org

Connecticut

Qualidigm
100 Roscommon Drive, Suite 200
Middletown, CT 06457
Local: 1-860-632-2008
Tollfree: 1-800-553-7590
Hours: 8:00 am - 4:30pm
www.qualidigm.org

Delaware

Quality Insights of Delaware
Plaza III, 1847 Marsh Road
Wilmington, DE 19810
Local: 1-302-478-3600
Hours: 8:15am - 5:00pm
www.qide.org

District of Columbia

Delmarva Foundation for Medical Care
1620 L Street, NW, Suite 1275
Washington, DC 20036
Local: 1-202-293-9650 (or
(410) 822-0697)
Tollfree: 1-800-999-3362
(or (800) 492-5811)
Spanish: 1-800-744-4344
Fax: 1-202-293-3253
Hours: 8:00am-5:00pm
www.dfmc.org

Florida

FL Medical Quality Assurance
4350 W. Cypress St., Suite 900
Tampa, FL 33607
Local: 1-813-354-9111
Tollfree: 1-800-844-0795
Hours: 8:00am-4:30pm
www.fmqai.com

Georgia

Georgia Medical Care Foundation
1455 Lincoln Parkway, Suite 800
Atlanta, GA 30346
Local: 1-404-982-0411
Tollfree: 1-800-979-7217
Hours: 8:00am-5:00pm
www.gmcf.org

Hawaii

Mtn.-Pacific Quality Health Foundation
1360 S. Beretania Street, Suite 501
Honolulu, HI 96814
Local: 1-808-545-2550
Tollfree: 1-800-524-6550
Fax: 1-808-440-6030
Hours: 8:00am-4:30pm
www.mpqhf.org

Idaho

QualisHealth
720 Park Boulevard, Suite 120
Boise, ID 83712
Local: 1-208-343-4617
Tollfree: 1-800-488-1118
Hours: 8:00am-5:00pm
www.qualishealth.org

Illinois

IL Foundation for Quality Health Care
2625 Butterfield Road, Suite 104S
Oakbrook, IL 60523
Local: 1-630-571-5540
Tollfree: 1-800-386-6431
Fax: 1-630-571-5611
Hours: 8:00am - 4:30pm
www.ifqhc.org

Indiana

Health Care Excel, Inc.
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, IN 46214
Local: 1-317-347-4500 (or (812) 234-1499
(TerreHaute))
Tollfree: 1-800-288-1499
Fax: 1-812-232-6167
Hours: 8:00am - 5:00pm
www.hce.org

Iowa

Iowa Foundation for Medical Care
 6000 Westown Parkway, Suite 350E
 West Des Moines, IA 50266
 Local: 1-515-223-2900
 Tollfree: 1-800-752-7014
 Fax: 1-515-222-2407
 www.ifmc.org

Kansas

Kansas Foundation for Medical Care
 2947 S.W. Wanamaker Drive
 Topeka, KS 66614
 Local: 1-785-273-2552
 Tollfree: 1-800-432-0407
 Fax: 1-785-273-0237
 Hours: 8:00am - 4:30pm
 www.kfmc.org

Kentucky

Health Care Excel
 9300 Shelbyville Rd., Suite 600
 Louisville, KY 40222
 Local: 1-502-339-7442
 Tollfree: 1-800-288-1499
 Fax: 1-812-232-6167
 Hours: 8:00am - 5:00pm
 www.hce.org

Louisiana

Louisiana Health Care Review
 8591 United Plaza Boulevard, Ste.270
 Baton Rouge, LA 70809
 Local: 1-225-926-6353
 Tollfree: 1-800-433-4958
 Fax: 1-225-928-3787
 Hours: 8:30am-5:00pm CT
 www.lhcr.org

Maine

Northeast Health Care Quality Found.
 15 Old Rollinsford Road, Suite 302
 Dover, NH 03820
 Local: 1-603-749-1641
 Tollfree: 1-800-772-0151
 Fax: 1-603-749-1195
 Hours: 8:30-4:30pm
 www.nhcfqf.org

Maryland

Delmarva Found. for Medical Care
 9240 Centreville Road
 Easton, MD 21601
 Local: 1-410-822-0697
 Tollfree: 1-800-492-5811
 Fax: 1-410-822-1997
 Hours: 8:00am-5:00pm
 www.dfmc.org

Massachusetts

MassPRO
 235 Wyman Street
 Waltham, MA 02451
 Local: 1-781-890-0011
 Tollfree: In-State Calls Only
 1-800-252-5533
 Hours: 8:30 am - 5:00 pm
 www.masspro.org

Michigan

MI Peer Review Organization
 22670 Haggerty Road, Suite 100
 Farmington Hills, MI 48335-2611
 Local: 1-248-465-7300
 Tollfree: 1-800-365-5899
 Hours: 9:00 am - 4:30 pm
 www.mpro.org

Minnesota

Stratis Health
 2901 Metro Drive, Suite 400
 Bloomington, MN 55425
 Local: 1-952-854-3306
 Tollfree: 1-800-444-3423
 Fax: 1-952-853-8503
 Hours: 8:00am-5:00pm
 www.stratishealth.org

Mississippi

Information and Quality Healthcare
 385 Highland Colony Parkway, Ste. 120
 Ridgeland, MS 39157
 Local: 1-601-957-1575
 Tollfree: 1-800-844-0600
 www.iqh.org

Missouri

Primaris
 200 North Keene Street
 Columbia, MO 65201
 Local: 1-573-817-8300
 Tollfree: 1-800-735-6776
 Fax: 1-573-817-8330
 Hours: 8:30 am - 4:30 pm
 www.primaris.org

Montana

Mtn.-Pacific Quality Health Foundation
 3404 Cooney Drive
 Helena, MT 59602
 Local: 1-406-443-4020
 Tollfree: 1-800-497-8232
 www.mpqhf.org

Nebraska

CIMRO of Nebraska
 1230 O Street, Suite 120
 Lincoln, NE 68508
 Local: 1-402-476-1399
 Tollfree: 1-800-247-3004
 Fax: 1-402-476-1335
 Hours: 8:00am-5:00pm M-F
 www.cimronebraska.org

Nevada

HealthInsight
 500 South Rancho Drive, Suite C-17
 Las Vegas, NV 89106
 Local: 1-702-385-9933
 Tollfree: 1-800-748-6773
 Fax: 1-702-385-4586
 Hours: 8:30am-5:00pm
 www.healthinsight.org

New Hampshire

Northeast Health Care Quality Found.
 15 Old Rollinsford Road, Suite 302
 Dover, NH 03820
 Local: 1-603-749-1641
 Tollfree: 1-800-772-0151
 Fax: 1-603-749-1195
 Hours: 8:30-4:40pm
 www.nhcfqf.org

New Jersey

Healthcare Quality Strategies, Inc.
 557 Cranbury Road, Suite 21
 East Brunswick, NJ 08816-4026
 Local: 1-732-238-5570
 Tollfree: In-State Calls Only
 1-800-624-4557
 www.pronj.org

New Mexico

New Mexico Medical Review Assn.
 2340 Menaul NE, Ste. 300
 Albuquerque, NM 87107
 Local: 1-505-998-9898
 Tollfree: 1-800-663-6351
 Fax: 1-505-998-9899
 www.nmmra.org

New York

Island Peer Review Organization - IPRO
 1979 Marcus Avenue, Suite 105
 Lake Success, NY 11042
 Local: 1-516-326-7767
 Tollfree: 1-800-331-7767
 www.ipro.org

North Carolina

Medical Review of North Carolina, Inc.
5625 Dillard Drive, Suite 203
Cary, NC 27511
Local: 1-919-851-2955
Tollfree: 1-800-722-0468
Hours: 8:00am-5:00pm
www.mrnc.org

North Dakota

North Dakota Health Care Review
800 31st Avenue, SW
Minot, ND 58701
Local: 1-701-852-4231
Tollfree: 1-888-472-2902
Fax: 1-701-838-6009
Hours: 7:00am - 4:00pm
www.ndhcri.org

Ohio

Ohio KePRO
5700 Lombardo Center Drive, Ste. 100
Seven Hills, OH 44131
Local: 1-216-447-9604
Tollfree: 1-800-589-7337
Fax: 1-216-447-7925
Hours: 8:00am - 4:30pm
www.keypro.com

Oklahoma

OK Foundation for Medical Quality
14000 Quail Springs Pkwy, Suite 400
Oklahoma City, OK 73134
Local: 1-405-840-2891
Fax: 1-405-840-1343
Hours: 8:00am - 5:00pm
www.ofmq.com

Oregon

OR Medical Professional Review Organization (OMPRO)
2020 SW Fourth Avenue, Suite 520
Portland, OR 97201
Local: 1-503-279-0100
Tollfree: 1-800-344-4354
Fax: 1-503-279-0190
Hours: 8:00am-5:00pm
www.ompro.org

Pennsylvania

Quality Insights of Pennsylvania
2601 Market Place St. Suite 320
Harrisburg, PA 17110
Local: 1-304-346-9864
Tollfree: 1-877-346-6180
Fax: 1-304-346-9863
Hours: 9:00am - 4:00pm
www.qipa.org

Rhode Island

Rhode Island Quality Partners, Inc.
235 Promenade St. Suite 500, Box 18
Providence, RI 02908
Local: 1-401-528-3200
Tollfree: 1-800-662-5028
www.riqualitypartners.org

South Carolina

Carolina Center for Medical Excellence
250 Berryhill Road, Suite 101
Columbia, SC 29210
Local: 1-803-731-8225
Tollfree: In-State Calls Only
1-800-922-3089
www.mrnc.org

South Dakota

SD Foundation for Medical Care
1323 South Minnesota Avenue
Sioux Falls, SD 57105
Local: 1-605-336-3505
Tollfree: 1-800-658-2285
Fax: 1-605-336-0270
Hours: 8:00am - 5:00pm
www.sdfmc.org

Tennessee

Foundation for Medical Care, Inc. of the Mid South
3175 Lenox Park Boulevard, Suite 309
Memphis, TN 38115
Local: 1-901-682-0381
Tollfree: 1-800-489-4633
Fax: 1-901-761-3786
Hours: 8:30am-5:00pm
www.qsource.org

Texas

Texas Medical Foundation
901 Mopac Expressway South
Barton Oaks Plaza Two, Suite 200
Austin, TX 78746-5799
Local: 1-512-329-6610
Tollfree: 1-800-725-8315
Fax: 1-512-327-7159
www.tmf.org

Utah

HealthInsight
348 E 4500 South, Suite 300
Salt Lake City, UT 84107
Local: 1-801-892-0155
Tollfree: 1-800-274-2290
Fax: 1-702-385-4586
Hours: 8:30am-5:00pm
www.healthinsight.org

Vermont

Northeast Health Care Quality Found.
15 Old Rollinsford Road, Suite 302
Dover, NH 03820
Local: 1-603-749-1641
Tollfree: 1-800-772-0151
Fax: 1-603-749-1195
Hours: 8:30-4:30pm
www.nhcqf.org

Virginia

Virginia Health Quality Center
4510 Cox Road, Suite 400
Glen Allen, VA 23060
Local: 1-804-289-5320
Tollfree: 1-800-545-3814
Fax: 1-804-289-5324
Hours: 8:30am-5:00pm
www.vhqc.org

Washington

QualisHealth
10700 Meridian Ave. North, Ste. 100
Seattle, WA 98133
Local: 1-206-364-9700
(or (206) 368-8272)
Tollfree: 1-877-575-8309
Hours: 8:00am-5:30pm
www.qualishealth.org

West Virginia

West Virginia Medical Institute, Inc.
3001 Chesterfield Place
Charleston, WV 25304
Local: 1-304-346-9864
Tollfree: 1-800-642-8686 x266
Hours: 8:00am-5:00pm
www.wvmi.org

Wisconsin

MetaStar
2909 Landmark Place
Madison, WI 53713
Local: 1-608-274-1940
Tollfree: 1-800-362-2320
Fax: 1-608-274-5008
Hours: 8:00am-4:30pm
www.metastar.com

Wyoming

Mtn.-Pacific Quality Health Found.
1950 Bluegrass Circle, Suite 280
Cheyenne, WY 82009
Local: 1-406-443-4020
Tollfree: 1-800-497-8232
Hours: 8am - 5pm
www.mpqh.org

State Pharmacy Assistance Programs (SPAPs)

Alaska

SeniorCare

SeniorCare Senior Information Office
3601 C Street, Suite 310
Anchorage, AK 99503-5984
Phone (In State): 1-800-478-6065
Phone (Out of state):(907) 269-3680
Fax: (907) 269-3688
www.hss.state.ak.us/dsds/seniorcaresio.htm

California

Genetically Handicapped Persons Program

MS 8105, P.O. Box 997413
Sacramento, CA 95899-7413
Phone (In State): 800-639-0597
Phone (Out of state):916-327-0470
Fax: 916-327-1112
www.dhs.ca.gov/pcfh/cms/ghpp/

Connecticut

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE)

CT Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Phone (In State): 1-800-423-5026
Phone (Out of state):1-860-832-9265
www.connpace.com/

Delaware (2)

Chronic Renal Disease Program

The Division of Social Services, The Lewis Building
1901 N. Du Pont Hwy.,
P.O. Box 906
New Castle, DE 19720
Phone (In State): (302) 422-1393
Phone (Out of state):1-800-372-2022
www.dhss.delaware.gov/dhss/dss/crdprog.html

Prescription Assistance Program

The Division of Social Services
1901 N. Du Pont Hwy., P.O. Box 906
New Castle, DE 19720
Phone (In State): 1-800-996-9969 x17
www.dhss.delaware.gov/dhss/dss/dpap.html

Florida

Florida Comprehensive Health Association

820 East Park Avenue Suite D200
Tallahassee, FL 32301
Phone 1-850-309-1200

Illinois (2)

Circuit Breaker

421 East Capitol Avenue, #100
Springfield, IL 62701-1789
Phone (In State): 217-785-3356
Phone (Out of state):1-800-252-8966
Fax: 217-785-4477
www.cbrx.il.gov/

Illinois Cares Rx Program

P.O. Box 19021
Springfield, IL 62794-9021
Phone (In State): 1-800-252- 8966 (Voice & TTY)
Phone (Out of state):1-800-624-2459
www.illinoisbenefits.org/ilcares.html

Indiana

Hoosier Rx

P.O. Box 6224
Indianapolis IN 46206-6224
Phone (In State): 1-317-234-1381
Phone (Out of state):1-866-267-4679 (toll-free)
www.in.gov/fssa/hoosierx/

Massachusetts

Prescription Advantage

Executive Office of Elder Affairs
One Ashburton Place, 5th floor
Phone (In State): 1-800-243-4636
Phone (Out of state):1-877-610-0241
www.800ageinfo.com/

Maine

Low Cost Drugs for the Elderly and Disabled

126 Sewall Street
Augusta ME 04330
Phone (In State): (207) 626-7058
Phone (Out of state):1-866-626-7059
Fax: (207) 621-8148
www.mejp.org/drugprograms.htm

Maryland (2)

Kidney Disease Program of Maryland

201 West Preston Street, Room 314A
Baltimore, MD 21201
410-767-5000

Maryland Senior Prescription Drug Assistance Program

Maryland Pharmacy Program
P.O. Box 386
Baltimore, Maryland 21203-0386
Phone (In State): 1-800-226-2142

Missouri

Missouri Rx Plan

PO Box 6500
205 Jefferson Street, Room 1310
Jefferson City, MO 65101
Phone: 1-800-375-1406
email: clinical.services@dss.mo.gov

Montana (2)

Big Sky Rx Program

1400 Broadway
Helena, MT 59601
Phone (In State): 1-866-369-1233
Phone (Out of state):1-406-444-1233 (from Helena or out of state)
www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml

Mental Health Services Plan

555 Fuller Ave
PO Box 202905
Helena, MT 59620-2905
Phone (In State): (406) 444-3964
Fax: (406) 444-4435
www.dphhs.mt.gov/aboutus/divisions/addictivementaldisorders/index.shtml

North Carolina

Senior Care

All benefits for Senior Care members ended 12-31-05 when the Medicare prescription Drug program began.
www.ncseniorcare.com/

New Jersey (2)

Prescription Assistance to the Aged and Disabled Program (PAAD)

P. O. Box 360
Trenton, NJ 08625-0360
Phone (In State): 1-800-792-9745
Phone (Out of state):1-877-222-3737
www.state.nj.us/health/seniorbenefits/pbp/paad-home.shtml

Senior Gold

NJ Dept. of Health & Senior Svcs.
P. O. Box 360
Trenton, NJ 08625-0360
Phone (In State): 1-800-792-9745
Phone (Out of state):1-877-222-3737
www.state.nj.us/health/seniorbenefits/pbp/senior-gold.shtml

Nevada (2)

Disability Rx Program

Department of Human Resources
1761 E College Pkwy, Bldg B, Ste 113
Carson City, NV 89706-7954
Phone (In State): 775-687-8711
Phone (Out of state): 1-866-303-6323
nevadaseniorr.nv.gov/

Senior Rx Program

Department of Human Resources
1761 E College Pkwy, Bldg B, Ste 113
Carson City, NV 89706-7954
Phone (In State): 775-687-8711 Reno-Carson
City-Gardnerville area
Phone (Out of state): outside these areas call toll-free 1-866-303-6323
nevadaseniorr.nv.gov/

New York

Elderly Pharmaceutical Insurance Coverage (EPIC)

P.O. Box 15018
Albany, NY 12212-5018
Phone (In State): 1-800-332-3742
TTY 1-800-290-9138
www.health.state.ny.us/health_care/epic/

Pennsylvania (3)

Pharmaceutical Assistance Contract for the Elderly (PACE)

555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919
Phone (In State): 1-800-225-7223
Phone (Out of State): 717-787-7313
Fax: 717- 772-2730

PACE Needs Enhancement Tier (PACENET)

Commonwealth of Pennsylvania
Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919
Phone (In State): 1-800-225-7223
Phone (Out of state): 717-787-7313
Fax: 717- 772-2730

Pennsylvania Chronic Renal Disease Program and General Assistance Program

7th and Forster Streets
7th Floor, East Wing
Harrisburg, PA 17120
Phone (In State): 1-877-724-3258
Phone (Out of state): 717-772-2762

Rhode Island

Rhode Island Prescription Assistance for the Elderly (RIPAE)

RI Department of Elderly Affairs
35 Howard Avenue
Cranston, RI 02920
Phone (In State): 401-462-4000
Phone (Out of state): 401-462-0740
www.dea.state.ri.us/

South Carolina

Gap Assistance Program for Seniors

Dept of Health and Human Svcs
P.O. Box 8206
Columbia, SC 29202
Phone (In State): 1-888-549-0820
www.dhhs.state.sc.us/dhhsnew/index.asp

Texas (2)

Kidney Health Care Program

TX Dept. of State Health Services
1100 West 49th Street, Mail Code 1938;
Department ID G31000
Austin, Texas 78756
Phone (In State): (512) 458-7150
Phone (Out of state): 1-800-222-3986
Fax: (512) 458-7162
www.dshs.state.tx.us/kidney/default.shtm

Mental Health Medication Program

P.O. Box 12668
Austin, TX 78711-2668
Phone (In State): (512) 206-4747 (phone)
Phone (Out of state): 1-800-252-8154

US Virgin Islands

Senior Citizens Affairs Pharmaceutical Assistance Program

Phone: 340-774-5265 x2 in
St. Thomas/St. John
Phone: 340-773-2323 x2023 in
St. Croix.
www.ltg.gov.vi/departments/medicare_office/medicarepdc.html

Vermont

V-Pharm

103 South Main Street
Waterbury, VT 05676-1201
Phone (In State): 1-802-241-2800
Phone (Out of state): 1-800-287-0589
www.dsw.state.vt.us/

Washington

Washington State Health Insurance Pharmacy Assistance Program

Listed by CMS as a qualified SPAP as of 11/8/05
(No further information available):

Wisconsin (5)

Chronic Renal Disease

Wisconsin Chronic Renal Disease Program
P.O. Box 1508
Madison, WI 53701-1508
Phone (In State): 1-608-266-2469
dhfs.wisconsin.gov/wcdp/index.htm

Cystic Fibrosis Program

WCDP
P.O. Box 6410
Madison, WI 53716-0410
Phone (In State): 1-608-221-3701
dhfs.wisconsin.gov/wcdp/index.htm

Health Insurance Risk Sharing Plan (HIRSP)

1751 W. Broadway
P.O. Box 8961
Madison, WI 53708-8961
Phone (In State): 1-800-828-4777
Phone (Out of state): 1-608-221-4551
Fax: 1-608-226-8770
www.dhfs.state.wi.us/hirsp/index.htm

Hemophilia Home Care

WCDP
P.O. Box 6410
Madison, WI 53716-0410
Phone (In State): (608) 221-3701
dhfs.wisconsin.gov/wcdp/index.htm

SeniorCare (above 200% FPL)

Department of Health and Family Services
1 W. Wilson Street
Madison, WI 53702
Phone (In State): 1-800-657-2038
www.dhfs.state.wi.us/seniorcare/

For the most up-to-date information on SPAPs, please visit:
www.medicare.gov/spap.asp

State Medicaid Offices

Alaska

AK Dept. of Health & Social Svcs.
350 Main Street, Room 404
PO Box 110601
Juneau, Alaska 99811-0601
Phone: (907) 465-3030
Fax: (907) 465-3068
TDD/TTY: (907) 586-4265

Alabama

Medicaid Agency of Alabama
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
local: 1-334-242-5000
toll-free: 1-800-362-1504
fax: 1-334-353-5989

Arkansas

Dept. of Health & Human Svcs. of AR
P.O. Box 1437, Slot 1100
Donaghey Plaza South
Little Rock, AR 72203-1437
local: 1-501-682-8292
toll-free: 1-800-482-5431 (eligibility call 1-800-482-8988)
TTY/TDD: 1-501-682-6789
fax: 1-501-682-1197

Arizona

Health Care Cost Containment of AZ
801 E. Jefferson
Phoenix, AZ 85034
local: 1-602-417-4000
toll-free: 1-800-962-6690
toll-free: 1-800-523-0231
TTY/TDD: 1-602-417-4191
fax: 1-602-252-2136

California

CA Dept. of Health Svcs.
P.O. Box 997413
Sacramento, CA 95899-7413
local: 1-916-440-7400

Colorado

Dept. of Health Care Policy and Financing of CO
1570 Grant Street
Denver, CO 80203-1818
local: 1-303-866-2993
toll-free: 1-800-221-3943
TTY/TDD: 1-303-866-3883
fax: 1-303-866-4411

Connecticut

Dept. of Social Svcs. of CT
25 Sigourney Street
Hartford, CT 06106-5033
local: 1-860-424-4908
toll-free: 1-800-842-1508 (in-state calls only)
fax: 1-860-951-9544

District of Columbia

DC Dept. of Human Services
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004
202-724-5506

Delaware

DE Division Of Medicaid & Medical Assistance
1901 N. DuPont Highway
P.O. Box 906, Lewis Bldg.
New Castle, DE 19720
local: 1-302-255-9500
fax: 1-302-255-4454

Florida

Agency for Health Care Administration of FL
2727 Mahan Drive
Tallahassee, FL 32308
toll-free: 1-888-419-3456
fax: 1-850-922-7703

Georgia

GA Dept. of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
local: 1-404-298-1228
toll-free: 1-800-766-4456

Hawaii

Dept. of Human Svcs. of HI
1390 Miller Street, Room 209
Honolulu, HI 96813
local: 1-808-586-5390
fax: 1-808-586-5718

Iowa

IA Medicaid Enterprise
P. O. Box 36510
Des Moines, Iowa 50315
local: 1-515-725-1003
toll-free: 1-800-338-8366

Idaho

ID Dept. of Health and Welfare
450 West State Street
Boise, ID 83720-0036
local: 1-208-334-5500
toll-free: 1-800-685-3757

Illinois

IL Dept. of Healthcare and Family Svcs.
201 South Grand Avenue, East
Springfield, IL 62763
local: 1-217-782-1200
toll-free: 1-866-468-7543

Indiana

Family and Social Svcs. Administration of IN
402 W. Washington Street
P.O. Box 7083
Indianapolis, IN 46207-7083
local: 1-317-233-4454
toll-free: 1-800-889-9949
fax: 1-317-233-4693

Kansas

Dept. of Social and Rehabilitation Svcs. of KS
915 SW Harrison Street
Topeka, KS 66612
local: 1-785-274-4200
toll-free: 1-800-766-9012
TTY/TDD: 1-785-296-1491
fax: 1-785-296-2173

Kentucky

Cabinet for Health Svcs. of KY
P.O. Box 2110
Frankfort, KY 40602-2110
local: 1-502-564-4321
toll-free: 1-800-635-2570
fax: 1-502-226-1898

Louisiana

LA Dept. of Health and Hospital
P.O. Box 91278
Baton Rouge, LA 70821-9278
local: 1-225-342-9500
fax: 1-225-342-5568

Massachusetts

MA Office of Health and Human Svcs.
600 Washington Street
Boston, MA 02111
toll-free: 1-800-325-5231
fax: 1-617-210-5820

Maryland

Dept. of Health and Mental Hygiene
P.O. Box 17259
Baltimore, MD 21203-7259
local: 1-410-767-5800
toll-free: 1-800-492-5231
fax: 1-410-333-7141

Maine

ME Dept. of Health and Human Svcs.
442 Civic Center Drive
11 State House Station
Augusta, ME 04333-0011
local: 1-207-624-7539 (eligibility)
toll-free: 1-800-977-6740
TTY/TDD: 1-207-287-1828
fax: 1-207-287-9229

Michigan

MI Dept. Community Health
Sixth Floor, Lewis Cass Building
320 South Walnut Street
Lansing, MI 48913
local: 1-517-373-3740
TTY/TDD: 1-517-373-3573

Minnesota

Dept. of Human Svcs. of MN
444 Lafayette Road North
St. Paul, MN 55155
local: 1-651-297-3933
toll-free: 1-800-333-2433
TTY/TDD: 1-651-296-5705
fax: 1-651-296-5690

Missouri

Dept. of Social Svcs. of MO
221 West High Street
P.O. Box 1527
Jefferson City, MO 65102-1527
local: 1-573-751-4815
toll-free: 1-800-392-2161 (in-state calls only)
fax: 1-573-751-6564

Mississippi

MS Division of Medicaid
239 North Lamar St., Suite 801
Robert E. Lee Bldg.
Jackson, MS 39201-1399
local: 1-601-359-6050
toll-free: 1-800-421-2408
TTY/TDD: 1-800-855-1000
fax: 1-601-359-6048

Montana

MT Dept. of Public Health &
Human Svcs.
1400 Broadway, Cogswell Bldg.
P.O. Box 8005
Helena, MT 59604-8005
local: 1-406-444-4540
toll-free: 1-800-362-8312 (in-state calls only)
fax: 1-406-444-2547

North Carolina

NC Dept. of Health and Human Svcs.
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
local: 1-919-855-4100
TTY/TDD: 1-877-733-4851
fax: 1-919-733-6608

North Dakota

Dept of Human Svcs. of ND -
Medical Svcs.
600 E. Boulevard Avenue
Bismarck, ND 58505-0250
local: 1-701-328-2321
toll-free: 1-800-755-2604
TTY/TDD: 1-701-328-8950
fax: 1-701-328-1060

Nebraska

NE Dept. of Health and Human
Svcs. System
P.O. Box 95044
Lincoln, NE 68509-5044
local: 1-402-471-3121
toll-free: 1-800-430-3244
TTY/TDD: 1-402-471-9570

New Hampshire

NH Dept. of Health and Human Svcs.
129 Pleasant Street
Concord, NH 03301-3857
local: 1-603-271-4238
toll-free: 1-800-852-3345 (in-state calls only)

New Jersey

Dept. of Human Svcs. of NJ
Quakerbridge Plaza, Building 7
P.O. Box 712
Trenton, NJ 08625-0712
local: 1-609-588-2600
toll-free: 1-800-356-1561 (in-state calls only)
fax: 1-609-588-3583

New Mexico

Dept. of Human Svcs. of NM
P.O. Box 2348
Sante Fe, NM 87504-2348
local: 1-505-827-3100
toll-free: 1-888-997-2583
TTY/TDD: 1-505-827-3184
fax: 1-505-827-3185

Nevada

NV Dept. of Human Resources, Aging Division
1100 East William Street
Suite 101
Carson City, NV 89701
local: 1-775-684-7200
fax: 1-775-687-3893

New York

NY State Dept. of Health
Office of Medicaid Management
Governor Nelson A. Rockefeller Empire State
Plaza, Corning Tower Building
Albany, NY 12237
local: 1-518-486-9057
toll-free: 1-800-541-2831
fax: 1-518-486-6852

Ohio

Dept. of Job and Family Svcs. of Ohio - Ohio
Health Plans
30 East Broad St., 31st Floor
Columbus, OH 43215-3414
local: 1-614-728-3288
toll-free: 1-800-324-8680
fax: 1-614-752-3986

Oklahoma

Health Care Authority of OK
4545 N. Lincoln Blvd., Ste. 124
Oklahoma City, OK 73105
local: 1-405-522-7171
toll-free: 1-800-522-0310
TTY/TDD: 1-405-522-7179
fax: 1-405-522-7100

Oregon

OR Dept. of Human Svcs.
500 Summer Street, NE
3rd Floor
Salem, OR 97310-1014
local: 1-503-945-5772
toll-free: 1-800-527-5772 (in-state calls only)
TTY/TDD: 1-503-945-5895
fax: 1-503-373-7689

Pennsylvania

Dept. of Public Welfare of PA
Health & Welfare Bldg., Rm 515
P.O. Box 2675
Harrisburg, PA 17105
local: 1-717-787-1870
toll-free: 1-800-692-7462
TTY/TDD: 1-717-705-7103

Rhode Island

Dept. of Human Svcs. of RI
Louis Pasteur Building
600 New London Avenue
Cranston, RI 02921
local: 1-401-462-5300
toll-free: 1-800-984-8989 (in-state calls only)
TTY/TDD: 1-401-462-3363
fax: 1-401-521-4875

South Carolina

SC Dept. of Health and Human Svcs.
P.O. Box 8206
Columbia, SC 29202-8206
local: 1-803-898-2500

South Dakota

Dept. of Social Svcs. of SD
700 Governors Drive
Richard F Kneip Bldg,
Pierre, SD 57501
local: 1-605-773-3495
toll-free: 1-800-452-7691 (in-state calls only)
fax: 1-605-773-5246

Tennessee

Bureau of TennCare
310 Great Circle Rd.
Nashville, TN 37243
toll-free: 1-866-311-4287
fax: 1-615-741-0882

Texas

TX Health and Human Svcs. Commiss.
4900 N. Lamar Boulevard, 4th Floor
Austin, TX 78701
local: 1-512-424-6500
toll-free: 1-888-834-7406
TTY/TDD: 1-512-407-3250

Utah

Utah Dept. of Health
288 North 1460 West, P.O. Box 143101
Salt Lake City, UT 84114-3101
local: 1-801-538-6155
toll-free: 1-800-662-9651
fax: 1-801-538-6805

Virginia

Dept. of Medical Assistance Svcs.
600 East Broad St., Ste. 1300
Richmond, VA 23219
local: 1-804-786-6273
toll-free: 1-800-552-8627 (in-state calls only)
fax: 1-804-225-4512

Vermont

Agency of Human Svcs. of VT
103 South Main Street
Waterbury, VT 05676-1201
local: 1-802-879-5900
toll-free: 1-800-250-8427 (in-state calls only)
TTY/TDD: 1-802-241-1282
fax: 1-802-241-2897

Washington

Dept. of Social and Health Svcs. of WA
P.O. Box 45505
Olympia, WA 98504-5505
local: 1-800-562-6188
toll-free: 1-800-562-3022 (in-state calls only)
fax: 1-360-586-1209

Wisconsin

WI Dept. of Health and Family Svcs.
1 West Wilson Street
P.O. Box 309
Madison, WI 53701-0309
local: 1-608-221-5720
toll-free: 1-800-362-3002
TTY/TDD: 1-608-267-7371
fax: 1-608-221-8815

West Virginia

WV Dept. of Health & Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3709
local: 1-304-558-1700
fax: 1-304-558-2515

Wyoming

WY Dept. of Health
147 Hathaway Building
Cheyenne, WY 82002
local: 1-307-777-7531
TTY/TDD: 1-307-777-5648
fax: 1-307-777-6974

State Offices for Civil Rights (OCRs)

OCR of the Southeast

61 Forsyth St., Suite 3 B70
Atlanta, GA 30303
Local: 1-404-562-7886
Tollfree: 1-800-368-1019
TTY: 1-404-562-7884
Fax: 1-404-562-7881
Hours: 8:00 am – 4:30 pm
www.hhs.gov/ocr

OCR of Alaska, Idaho, Oregon, and Washington

2201 6th Avenue, M/S Rx 11
Seattle, WA 98121-1831
Local: 1-206-615-2290
Tollfree: 1-800-368-1019
TTY: 1-206-615-2296
Fax: 1-206-615-2297
Hours: 8:00 am – 4:30 pm
www.hhs.gov/ocr

OCR of the West

50 United Nations Plaza, Room 322
San Francisco, CA 94102
Local: 1-415-437-8310
Tollfree: 1-800-368-1019
TTY: 1-415-437-8311
Fax: 1-415-437-8329
Hours: 8:00 am – 4:30 pm
www.hhs.gov/ocr

OCR of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

1301 Young St., Suite 1169
Dallas, TX 75202
Local: 1-214-767-4057
Tollfree: 1-800-368-1019
TTY: 1-214-767-8940
Fax: 1-214-767-0432
Hours: 7:30 am – 4:30 pm
www.hhs.gov/ocr

OCR of Colorado, Montana, North Dakota, Utah, and Wyoming

Federal Office Bldg., 1961 Stout St.
Denver, CO 80294
Local: 1-303-844-2024
Tollfree: 1-800-368-1019
TTY: 1-303-844-3439
Fax: 1-303-844-2025
Hours: 8:00 am – 4:30 pm
www.hhs.gov/ocr

OCR of New England

JFK Federal Bldg., Room 1875
Boston, MA 02203
Local: 1-617-565-1340
Tollfree: 1-800-368-1019
TTY: 1-617-565-1343
Fax: 1-617-565-3809
Hours: 8:00 am – 4:30 pm
www.hhs.gov/ocr

OCR of the Mid-Atlantic

Public Ledger Bldg., 150 South Independence
Mall West, Suite 372,
Philadelphia, PA 19106
Local: 1-215-861-4441
Tollfree: 1-800-368-1019
TTY: 1-215-861-4440
Spanish: 1-800-368-1019
Fax: 1-215-861-4431
Hours: 9:30 am – 3:30 pm
www.hhs.gov/ocr

OCR of the Mid-West

105 West Adams, 16th Floor
Chicago, IL 60603
Local: 1-312-886-2359
Tollfree: 1-800-368-1019
TTY: 1-312-353-5693
Fax: 1-312-886-1807
Hours: 8:30 am – 5:00 pm
www.hhs.gov/ocr

OCR of Iowa, Kansas, Missouri, and Nebraska

601 East 12th St., Room 248
Kansas, MO 64106
Local: 1-816-426-7277
Tollfree: 1-800-368-1019
TTY: 1-816-426-7065
Fax: 1-816-426-3686
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26 Federal Plaza, Suite 3312
New York, NY 10278
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TTY: 1-212-264-2355
Fax: 1-212-264-3039
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OCR of South Dakota

118 West Capitol Avenue

Pierre, SD 57501

Local: 1-303-844-2024

Tollfree: 1-800-368-1019

TTY: 1-303-844-3439

Fax: 1-605-773-6893

E-mail: humanr@crpr1.state.sd.us

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West Virginia

OCR of the Mid-Atlantic

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OCR of the Mid-West

Wyoming

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