Evidence of Coverage and Disclosure Form

Effective January 1, 2027

Blue Shield of California Medicare Rx Plan (PDP)

Sponsored by California Correctional Peace Officers Association Benefit Trust Fund.

Approved by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

PDP-WK-CCPOA-1126

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Drug Coverage as a Member of Blue Shield of California Medicare Rx Plan (PDP)

This document gives the details of your Medicare drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Service at (800) 542-8364 (TTY users call 711). Hours are 8 a.m. to 8 p.m. PT, seven days a week. This call is free.

This plan, Blue Shield of California Medicare Rx Plan, is offered by California Physicians' Service (dba Blue Shield of California). (When this Evidence of Coverage says "we," "us," or "our," it means California Physician's Service (dba Blue Shield of California). When it says "plan" or "our plan," it means Blue Shield of California Medicare Rx Plan.)

This information may be available in a different format, including Braille, large print, audio cd and data cd. Please call Customer Service at the number above if you need plan information in another format. If you would like to receive your plan materials via email, log in at blueshieldca.com/login and go to your profile page by clicking "Edit profile" on your myblueshield dashboard and then select Yes, save paper, Send by Email as your delivery preference under Communications preferences. If you do not have an account, click on Create account, and select email as your delivery preference during the registration process.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

Blue Shield of California's pharmacy network includes limited lower-cost pharmacies with preferred cost sharing. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network

OMB Approval 0938-1051 (Expires: July 31, 2029)

pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call Customer Service at **(800) 542-8364** [TTY: **711**], 8 a.m. to 8 p.m. PT, seven days a week or consult the online pharmacy directory at **blueshieldca.com/ccpoa**.

Table of Contents

CHAPTER 1:
Get started as a member

SECTION 1 You're a member of Blue Shield of California Medicare Rx Plan

Section 1.1 You're enrolled in Blue Shield of California Medicare Rx Plan, which is a Medicare Drug Plan

You're covered by Blue Shield Group Medicare Advantage (PPO) for your health care coverage, and you chose to get your Medicare drug coverage through our plan, Blue Shield of California Medicare Rx Plan.

Blue Shield of California Medicare Rx Plan is a Medicare drug plan (PDP). Like all Medicare plans, this Medicare drug plan is approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

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

The contract is in effect for the months you're enrolled in Blue Shield of California Medicare Rx Plan between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Blue Shield of California Medicare Rx Plan after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan Eligibility Requirements

Section 2.1 Eligibility Requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B)
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.
- You meet your Plan Sponsor's eligibility requirements.

Section 2.2 Plan service area for Blue Shield of California Medicare Rx Plan

Blue Shield of California Medicare Rx Plan is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes all 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at **(800) 542-8364** (TTY users call **711**) or reach out to your Plan Sponsor to see if they have a plan in your new area.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Shield of California Medicare Rx Plan if you're not eligible to stay a member of our plan. Blue Shield of California Medicare Rx Plan must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your Blue Shield of California Medicare Rx Plan membership card for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample membership card:

Carry your card with you at all times and remember to show your card when you get covered drugs. If our plan membership card is damaged, lost, or stolen, call Customer Service at **(800) 542-8364** (TTY users call **711**) right away and we'll send you a new card.

You will need to use your CCPOA Medical Plan Medicare (PPO) membership card to get covered medical care and services under that plan.

Section 3.2 Pharmacy Directory

The *Pharmacy Directory* (**blueshieldca.com/ccpoa**), lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 3, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

The *Pharmacy Directory* also shows you which pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Customer Service at **(800) 542-8364** (TTY users call **711**). You can also find this information on our website at **blueshieldca.com/ccpoa**.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Blue Shield of California Medicare Rx Plan. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 3, Section 6. Medicare approved the Blue Shield of California Medicare Rx Plan Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. The Drug List includes information for the covered drugs most commonly used by our members. However, we also cover additional drugs that aren't included in the Drug List. If one of your drugs isn't listed in the Drug List, visit our website or call Customer Service at **(800) 542-8364** (TTY users call **711**) to find out if we cover it. To get the most complete and current information about which drugs are covered, visit **blueshieldca.com/ccpoa** or call Customer Service at **(800) 542-8364** (TTY users call **711**).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	**If you are responsible for any contribution to the monthly plan premium, your Plan Sponsor will tell you the amount and where to send payment.**
Part D drug coverage (Go to Chapter 4 Section 4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible** **$0** **Copayment during the Initial Coverage Stage:** **Drug Tier 1: $5** **Drug Tier 2: $20** **Drug Tier 3: $35** **Drug Tier 4: $50**

	Your Costs in 2027
	Catastrophic Coverage Stage: **During this payment stage, you pay nothing for your covered Part D drugs.** **You may have cost sharing for drugs that are covered under our enhanced benefit.**

Your costs may include the following:

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

Section 4.1 Plan Premium

Your coverage is provided through a contract with your Plan Sponsor. Contact the Plan Sponsor for information about your plan premium.

In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. Learn more about these programs in the exhibits at the end of this document. If you qualify, enrolling in one of these programs might lower your monthly plan premium.

If you *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Customer Service at **(800) 542-8364** (TTY users call **711**) and ask for the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2027* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website at

(Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Some members are required to pay other Medicare premiums

You must have either Part A and/or Part B to be enrolled in a Part D plan. Although most people do not have to pay for Part A, some do. If you have to pay for Part A, you must also have Part B, and in addition to paying the monthly plan premium, if applicable, you must continue paying your Medicare premiums to stay a member of our plan.

Section 4.3 Part D Late Enrollment Penalty

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

When you first enroll in Blue Shield of California Medicare Rx Plan*,* we let your Plan Sponsor know the amount of the penalty. Your Plan Sponsor will then have the option to add the penalty to your monthly premium or request other payment options. Please contact your Plan Sponsor for more information. Your Plan Sponsor will then have the option to add the penalty to your monthly premium or request other payment options. If you do not pay your Part D late enrollment penalty, your Plan Sponsor may dis-enroll you. Please contact your Plan Sponsor for more information.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.

- **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
- **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.78. This rounds to $5.80. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you won't have another chance to ask for a reconsideration of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

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

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

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

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

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a plan premium (if applicable) and/or Part D late enrollment penalty (if applicable), your Plan Sponsor will explain how you can pay your plan premium and/or Part D late enrollment penalty

If you pay a plan premium (if applicable) and/or Part D late enrollment penalty (if applicable), your Plan Sponsor will explain how you can pay your plan premium and/or Part D late enrollment penalty. Please contact your Plan Sponsor for more information about how to pay the plan premium (if applicable) and/or Part D late enrollment penalty (if applicable) and about the possible consequences of not doing so.

If your Plan Sponsor notifies us to end your membership because you did not pay your plan premium (if applicable) and/or Part D late enrollment penalty (if applicable), you will still have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time your former employer group/union notifies us to end your membership, you may still owe them for the plan premiums (if applicable) and/or Part D late enrollment penalty (if applicable) you have not paid. They have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you may need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 7 to learn how to make a complaint or call us at **(800) 542-8364** between 8 a.m. to 8 p.m. PT, seven days a week. TTY users call **711**. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, your Plan Sponsor will inform you at your Open Enrollment period and the new premium will take effect on January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of your plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premiums. If you lose your eligibility for Extra Help during the year, you'll need to start paying the full monthly premium. Find out more about Extra Help in Chapter 2, Section 7.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you disenroll from your plan and go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep your plan membership record up to date

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

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

If you have any of these changes, let us know:

- Changes to your name, address, or phone number*
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)*
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, let us know by calling Customer Service at **(800) 542-8364** (TTY users call **711**).

*Contact your Plan Sponsor with these changes also.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at **(800) 542-8364** (TTY users call **711**). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)

- Black lung benefits
- Workers' compensation

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 Blue Shield of California Medicare Rx Plan contacts

For help with claims, billing, or member card questions, call or write to Blue Shield of California Medicare Rx Plan Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
Call	**(800) 542-8364** Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. You can get this document for free in other formats, such as large print, braille, and/or audio by calling Customer Service. Customer Service **(800) 542-8364** (TTY users call **711**) also has free language interpreter services for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week.
Fax	(877) 251-6671
Write	Blue Shield of California Medicare Rx Plan P.O. Box 927, Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/ccpoa**

How to ask for a coverage decision or appeal

A coverage decision is a decision we make about your coverage or about the amount we pay for your Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your Part D drugs, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care or Part D drugs – Contact Information	
Call	**(800) 542-8364** Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(888)697-8122
Write	Blue Shield of California Medicare Rx Plan Attn: Pharmacy Authorization 3300 Zinfandel Drive Rancho Cordova, CA 95670
Website	**blueshieldca.com/medicare**

How to make a complaint

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint, go to Chapter 7.

Complaints – Contact Information	
Call	**(800) 542-8364** Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

	Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(916) 350-6510
Write	Blue Shield of California Medicare Rx Plan Appeals & Grievances Department P.O. Box 927, Woodland Hills, CA 91365-9856
Medicare website	To submit a complaint about Blue Shield of California Medicare Rx Plan directly to Medicare, go to Medicare.gov/MedicareComplaintForm/home.aspx.

How to ask us to pay our share of the cost of a drug you got

If you got a bill or paid for drugs (like a pharmacy bill) you think we should pay for, you may need to ask our plan for reimbursement or to pay the pharmacy bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	**(800) 542-8364** Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(916) 350-6510
Write	Claims Processing

	1606 Ave. Ponce de Leon San Juan, PR 00909-4830
Website	**blueshieldca.com/medicare**

SECTION 2 Get Help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Prescription Drug Plans, including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms.

- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.
- Look up helpful websites and phone numbers.

You can also visit Medicare.gov to tell Medicare about any complaints you have about Blue Shield of California Medicare Rx Plan.

To submit a complaint to Medicare, go to Medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES
• Visit https://www.shiphelp.org (click on SHIP LOCATOR in middle of page) and select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state. • Go to **Exhibit 1** at the end of this document for a list of phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organizations (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Refer to **Exhibit 2** at the end of this document for a list of the Quality Improvement Organizations in each state we serve.

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

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

SECTION 5 Social Security

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

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

Social Security– Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

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

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

To find out more about Medicaid and Medicare Savings Programs, contact your state Medicaid agency found in **Exhibit 3** at the end of this document.

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly premium, yearly deductible, and copayments and coinsurance. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- For assistance in obtaining evidence of your proper copayment level, you may call Customer Service (phone numbers are printed on the back cover of this booklet) and we can either mail or fax you a list of acceptable documents of evidence or read you the list over the phone. Once you obtain the evidence, or if you already have it, you may send it to us either by fax (877) 251-6671) or by mail (Blue Shield of California Medicare Rx Plan, P.O. Box 927, Woodland Hills, CA 91365-9856.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Service at **(800) 542-8364** (TTY users call **711**) if you have questions.

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about its rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" for more information. TTY users call 1-877-486-2048. You can also visit Medicare.gov for more information.

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

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

Refer to **Exhibit 4** at the end of this document for a list of SPAPs in each state we serve.

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

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the ADAP in your state. Refer to **Exhibit 5** at the end of this document for a list of ADAPs in each state we serve.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members. Refer to **Exhibit 4** at the end of this document for a list of ADAPs in each state we serve.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call Customer Service at **(800) 542-8364** (TTY users call **711**) or visit Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	**(833) 696-2087** Calls to this number are free. 8 a.m. to 8 p.m. EST, seven days a week from October 15 to December 7 and 8 a.m. to 8 p.m. EST, Monday through Friday, after December 7. Customer Service also has free language interpreter services for non-English speakers.
TTY	**711**

	This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. EST, seven days a week from October 15 to December 7 and 8 a.m. to 8 p.m. EST, Monday through Friday, after December 7.
Fax	(440) 557-6585
Write	SimplicityRx Blue Shield of California Medicare Rx Plan Medicare Prescription Payment Program Election Department 13900 N. Harvey Ave. Edmond, OK 73013
Website	**Activate.RxPayments.com**

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	RRB.gov

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the Plan Sponsor or Customer Service at **(800) 542-8364** (TTY users call **711**) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

CHAPTER 3:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, go to your *Medicare & You 2027* handbook.) Your Part D prescription drugs are covered under our plan.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through our plan's
- service.)
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain references. (Go to Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's home delivery service

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (**blueshieldca.com/ccpoa**), and/or call Customer Service at **(800) 542-8364** (TTY users call **711**).

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

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, call Customer Service at **(800) 542-8364** (TTY users call **711**) or use the *Pharmacy Directory*. You can also find information on our website at **blueshieldca.com/ccpoa**.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Customer Service at **(800) 542-8364** (TTY users call **711**).

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* **blueshieldca.com/ccpoa** or call Customer Service at **(800) 542-8364** (TTY users call **711**).

Section 2.2 Our plan's home delivery service

For certain kinds of drugs, you can use our plan's network home delivery service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through our plan's home delivery service are marked with the symbol **NDS** in our Drug List.

Our plan's home delivery service allows you to order **up to a 90-day supply for Tier 1: Generic Drugs, Tier 2: Preferred Brand Drugs, Tier 2: Covered Insulins, Tier 3: Non-Preferred Drugs and Tier 3: Covered Insulins, and up to a 30-day supply for Tier 4: Specialty Tier Drugs**.

To get information about filling your prescriptions by home delivery please call Customer Service at the number on the back cover of this booklet. If you use a home delivery service not in the plan's network, your prescription will not be covered.

Usually, a home delivery pharmacy order will be delivered to you in no more than 5 business days. You will receive a notification if there is a delay with your home delivery prescription order. If you have questions about this, please contact Amazon Pharmacy's Blue Shield-dedicated Customer Care team at **(856) 208-4665**, 24 hours a day, 7 days a week. TTY users call **711**. If needed, Blue Shield Customer Service can assist you in obtaining a sufficient supply of medication from a local retail network pharmacy, so you are not without medication until your home delivery medication arrives. This may require contacting your physician to have him/her phone or fax a new prescription to the retail network pharmacy for the quantity of medication needed until you receive your home delivery medication.

If the delay is greater than 5 days from the date the prescription was ordered from the home delivery provider and is due to a loss of medication in the home delivery system, Amazon Pharmacy's Blue Shield-dedicated Customer Care team can coordinate a replacement order.

New prescriptions the pharmacy gets directly from your doctor's office.
After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It's important to

respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or stop the new prescription.

Refills on home delivery prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the home delivery pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares home delivery refills, contact us by calling Amazon Pharmacy at **(856) 208-4665**, 24 hours a day, 7 days a week. TTY users call **711**.

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost sharing) at the home delivery cost-sharing amount. Other retail pharmacies may not agree to the home delivery cost-sharing amounts. In this case you'll be responsible for the difference in price. Your *Pharmacy Directory* (**blueshieldca.com/ccpoa**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at **(800) 542-8364** (TTY users call **711**) for more information.
2. You can also get maintenance drugs through our home delivery program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Customer Service at (800) 542-8364 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or home delivery service (these drugs include orphan drugs, high cost and unique drugs or other specialty pharmaceuticals).
- Some vaccines administered in your physician's office that are not covered under Medicare Part B and cannot reasonably be obtained at a network pharmacy may be covered under our out-of-network access.
- Prescriptions filled at out-of-network pharmacies are limited to a 30-day supply of covered medications.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 5, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or.

- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

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

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

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

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 7.)

Section 3.2 Four cost-sharing tiers for drugs on the Drug List

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

- Cost-Sharing Tier 1: Generic Drugs (lowest cost-sharing tier)
  Includes preferred generic drugs
- Cost-Sharing Tier 2: Preferred Brand Drugs
  Includes preferred brand name, generic drugs, and biosimilars.
- Cost-Sharing Tier 3: Non-Preferred Drugs

Includes non-preferred brand name, biosimilars, and some generic drugs.

- Cost-Sharing Tier 4: Specialty Tier Drugs (highest cost-sharing tier)
  Includes very high-cost brand name, biosimilars, and generic drugs which may require special handling and/or close monitoring

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (**blueshieldca.com/ccpoa**). The Drug List on the website is always the most current.
- Call Customer Service at **(800) 542-8364** (TTY users call **711**) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (**blueshieldca.com/pricecheck**) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Service at **(800) 542-8364** (TTY users call **711**).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

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

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Customer Service at **(800) 542-8364** (TTY users call **711**) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 7.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Customer Service at **(800) 542-8364** (TTY users call **711**) or on our website (**blueshieldca.com/ccpoa**).

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Customer Service at **(800) 542-8364** (TTY users call **711**) or on our website (**blueshieldca.com/ccpoa**).

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.

- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

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

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

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

  We'll cover one 31-day supply emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Customer Service at **(800) 542-8364** (TTY users call **711**).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Customer Service at **(800) 542-8364** (TTY users call **711**) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

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

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

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service at **(800) 542-8364** (TTY users call **711**) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

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

Drugs in our Tier 1: Generic Drugs and Tier 4: Specialty Tier Drugs aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-

sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.

- We'll make these immediate changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
- We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.

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

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

Changes to the Drug List that don't affect you during this plan year

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

In general, changes that won't affect you during the current plan year are:

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

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

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

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

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

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B. Please use your CCPOA Medical Plan Medicare (PPO) card for these drugs.
- Our plan can't cover a drug purchased outside the United States or its territories.

- Our plan can't cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may have cost sharing.)

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. To find out which drugs have enhanced drug coverage, review the most recent Drug List. You can identify enhanced drugs by the symbol **EDC** on the Drug List. The amount you pay for these drugs doesn't count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 6.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Customer Service at **(800) 542-8364** (TTY users call **711**) for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in **Exhibit 3** at the end of this document.)

SECTION 8 How to fill a prescription

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

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 5, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

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

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Pharmacy Directory* (**blueshieldca.com/ccpoa**) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Service at **(800) 542-8364** (TTY users call **711**). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about a temporary or emergency supply.

Section 9.3 If you are taking drugs covered by Original Medicare

Your enrollment in Blue Shield of California Medicare Rx Plan doesn't affect your coverage for drugs covered under Medicare Part A or Part B. Your prescriptions that are covered under Part

A or Part B would be covered under your CCPOA Medical Plan Medicare (PPO) plan. If your drug would be covered by Medicare Part A or Part B, our plan can't cover it.

Some drugs may be covered under Medicare Part B in some situations and through Blue Shield of California Medicare Rx Plan in other situations. Drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill CCPOA Medical Plan Medicare (PPO) plan and Blue Shield of California Medicare Rx Plan for the drug.

Section 9.4 If you also get drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's Plan Sponsor.** They can help you understand how your current drug coverage will work with our plan.

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

Special note about creditable coverage:

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

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

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's Plan Sponsor or the employer or union.

Section 9.6 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safely and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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

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

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

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

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

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

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

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Customer Service at **(800) 542-8364** (TTY users call **711**).

Chapter 4:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you are in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Customer Service at **(800) 542-8364** (TTY users call **711**) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (**blueshieldca.com/pricecheck**), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Customer Service at **(800) 542-8364** (TTY users call **711**).

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

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

These payments <u>are included</u> in your out-of-pocket costs

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

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>aren't included</u> in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B. You will use your CCPOA Medical Plan Medicare (PPO) card for these services
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward drugs not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)

- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Service at **(800) 542-8364** (TTY users call **711**).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,400, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for Blue Shield of California Medicare Rx Plan members

There are **3 drug payment stages** for your drug coverage under Blue Shield of California Medicare Rx Plan. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Keep in mind you are always responsible for our plan's monthly premium regardless of the drug payment stage. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your Part D *Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you moved from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pockets Costs:** this is how much you have paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

Section 3.1 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.

- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Service at **(800) 542-8364** (TTY users call **711**). Be sure to keep these reports.

SECTION 4 There is no deductible for Blue Shield of California Medicare Rx Plan

There is no deductible for *Blue Shield of California Medicare Rx Plan*. You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

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

Our plan has four cost-sharing tiers

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

- Cost-Sharing Tier 1: Generic Drugs (lowest cost-sharing tier)
  Includes preferred generic drugs
- Cost-Sharing Tier 2: Preferred Brand Drugs
  Includes preferred brand name, generic drugs and biosimilars.
- Cost-Sharing Tier 3: Non-Preferred Drugs
  Includes non-preferred brand name, biosimilars and some generic drugs.

- Cost-Sharing Tier 4: Specialty Tier Drugs (highest cost-sharing tier)
  Includes very high-cost brand name, biosimilars and generic drugs which may require special handling and/or close monitoring.

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

Your pharmacy choices

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

- A network retail pharmacy that offers standard cost sharing
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 3, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's home delivery pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 3 and our plan's *Pharmacy Directory* (**blueshieldca.com/ccpoa**).

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your costs for a *one-month* supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network) (up to a 30-day supply)	Preferred retail cost sharing (in-network) (up to a 30-day supply)	Home delivery cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Generic drugs)	$5 copayment	$5 copayment	Home delivery is not available for 30-day supply of drugs in Tier 1.	$5 copayment	$5 copayment
Cost-Sharing Tier 2 (Preferred Brand Drugs)	$20 copayment	$20 copayment	Home delivery is not available for 30-day supply of drugs in Tier 2.	$20 copayment	$20 copayment
Cost-Sharing Tier 2 (Covered Insulins*)	$20 copayment	$20 copayment	Home delivery is not available for 30-day supply of drugs in Tier 2.	$20 copayment	$20 copayment

Tier	Standard retail cost sharing (in-network) (up to a 30-day supply)	Preferred retail cost sharing (in-network) (up to a 30-day supply)	Home delivery cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 3 (Non-Preferred Drugs)	$35 copayment	$35 copayment	Home delivery is not available for 30-day supply of drugs in Tier 3.	$35 copayment	$35 copayment
Cost-Sharing Tier 3 (Covered Insulins*)	$35 copayment	$35 copayment	Home delivery is not available for 30-day supply of drugs in Tier 3.	$35 copayment	$35 copayment
Cost-Sharing Tier 4 (Specialty Tier Drugs)	$50 copayment	$50 copayment	$50 copayment	$50 copayment	$50 copayment

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

Go to Section 7 of this chapter for more information on cost sharing for Part D vaccines.

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

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

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

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

Section 5.4 Your costs for a long-term (to a 90-day) supply of a covered Part D drug

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

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

Your costs for a *long-term* (up to a 90-day) supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Home delivery cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Generic Drugs)	$15 copayment	$10 copayment	$10 copayment

Tier	**Standard retail cost sharing (in-network)** **(up to a 90-day supply)**	**Preferred retail cost sharing (in-network)** **(up to a 90-day supply)**	**Home delivery cost sharing** **(up to a 90-day supply)**
Cost-Sharing Tier 2 (Preferred Brand Drugs)	$60 copayment	$40 copayment	$40 copayment
Cost-Sharing Tier 2 (Covered Insulins*)	$60 copayment	$40 copayment	$40 copayment
Cost-Sharing Tier 3 (Non-Preferred Drugs)	$105 copayment	$70 copayment	$70 copayment
Cost-Sharing Tier 3 (Covered Insulins*)	$105 copayment	$70 copayment	$70 copayment
Cost-Sharing Tier 4 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 4.	A long-term supply is not available for drugs in Tier 4.	A long-term supply is not available for drugs in Tier 4.

You won't pay more than $70 for up to a 2-month supply or $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count toward your total out-of-pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,400 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.
- For excluded drugs covered under our enhanced benefit, you pay the cost sharing amounts listed in the tables shown above in Section 5.2 and 5.4.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to our plan's Drug List or call Customer Service at **(800) 542-8364** (TTY users call **711**) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
    - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
    - A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

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

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

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

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

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

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

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance *OR* copayment for the vaccine itself.

- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration.

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

SECTION 1 Situations when you should ask us to pay our share for covered drugs

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

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

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

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

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

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

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

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

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you're retroactively enrolled in our plan

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

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

Please call Customer Service for additional information about how to ask us to pay your back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet).

When you send us a request for payment, we'll review your request and decide whether the drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within three years** of the date you got the item or drug.

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

- You don't have to use the form, but it'll help us process the information faster.

- Download a copy of the form from our website (**blueshieldca.com**) or call Customer Service at **(800) 542-8364** (TTY users call **711**) and ask for the form.

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

Part D Prescription drug claims:
Claims Processing
1606 Ave. Ponce de Leon
San Juan, PR 00909-4830

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

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

- If we decide the drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the drug, we'll mail your reimbursement of our share of the cost to you.
- If we decide the drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the drug, you can make an appeal

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

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Spanish and braille, large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at **(800) 542-8364** (TTY users call **711**).

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, call to file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your protected health information, call Customer Service at **(800) 542-8364** (TTY users call **711**).

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

As a member of Blue Shield of California Medicare Rx Plan, you have the right to get several kinds of information from us. You also have a right to make recommendations regarding the Plan's Member Rights and Responsibilities.

If you want any of the following kinds of information, call Customer Service at **(800) 542-8364** (TTY users call **711**).

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

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

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

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Service at **(800) 542-8364** (TTY users call **711**) to ask for the forms.
- **Fill out the form and sign it.** No matter of where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with your state's Quality Improvement Organization. See **Exhibit 2** at the end of this document for contact information.

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

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

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Service at (800) 542-8364 (TTY users call 711)**
- **Call your local SHIP**. For details, go to **Exhibit 1** at the end of this document.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at (800) 542-8364 (TTY users call 711)**
- **Call your local SHIP**. For details, go to **Exhibit 1** at the end of this document.
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at **(800) 542-8364** (TTY users call **711**).

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

CHAPTER 7:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

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

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at **(800) 542-8364** (TTY users call **711**) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organization that can help are:

State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in **Exhibit 1** at the end of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048
- Visit Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 7, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get benefits

If you want to know if we'll cover a specific drug care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your prescription drugs.

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide a drug isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call Customer Service at (800) 542-8364 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Customer Service at **(800) 542-8364** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **blueshieldca.com/apptofrep**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

Section 5.1 What to do if you have problems getting a Part D drug or want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 3 and 4. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

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

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

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

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

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

Section 5.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

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

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 3: Non-Preferred Drugs*.* You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug list.
2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
   - If our Drug List contains an alternative drug(s) for treating your medical condition that is in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 4: Specialty Tier Drugs.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

Section 5.4 How to ask for a coverage decision, including an exception

Legal Terms:

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

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

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which is available on our website https://www.blueshieldca.com/en/medicare/member-resources/coverage-decisions-exceptions. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to provide **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review

organization. We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 5.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**.

A fast appeal is called an **expedited redetermination.**

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

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

- If you're appealing a decision we made about a drug, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.4 of this chapter.

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at (xxx) xxx-xxxx** (TTY: **711**), 8 a.m. to 8 p.m. PT, seven days a week. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website

blueshieldca.com/medappeals. Include your name, contact information, and information about your claim to help us process your request.

- You may also submit an appeal through our website; visit **blueshieldca.com/medappeals**.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.

   - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.
   - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 5.6 How to make a Level 2 appeal

Legal Term

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

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

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

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information we have about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

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

For fast appeals:

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

For standard appeals:

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

What if the independent review organization says no to your appeal?

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

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

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

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

SECTION 6 Taking your appeal to Levels 3, 4 and 5

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

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

If the dollar value of the drug you appealed meets certain minimum levels, you may be able to go to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

If the answer is yes, the appeals process is over. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision. **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

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

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

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

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you got
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at our plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Customer Service at (800) 542-8364 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Here's how it works:

- Step 1: File a Grievance

To begin the process, call a Customer Service representative within 60 calendar days of the event and ask to file a grievance. You may also file a grievance by fax or in writing within 60 calendar days of the event by sending it to:

Blue Shield of California Medicare Rx Plan
Appeals & Grievances Department
P.O. Box 927, Woodland Hills CA 91365-9856
FAX: (916) 350-6510

You may also call us to request a **Blue Shield of California Medicare Rx Plan Appeals & Grievance Form (**use of this form is optional).

We will send you a letter within 5 calendar days letting you know that we received the notice of your concern. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

If you ask for an *expedited grievance* because we decided not to give you a *fast decision* or *fast appeal* or because we asked for an extension on our initial decision or fast appeal, we will forward your request to a medical director who was not involved in our original decision. We may ask if you have additional information that was not available at the time you requested a *fast initial decision* or *fast appeal*.

The medical director will review your request and decide if our original decision was appropriate. We will send you a letter with our decision within 24 hours of your request for an *expedited grievance*.

- **Step 2: Grievance Hearing**
  If you are not satisfied with the resolution of your grievance related to a quality of care issue, you may make a written request to the Blue Shield of California Medicare Rx Plan Appeals & Grievances Department for a grievance hearing. Within 31 calendar days of your written request being received, we will assemble a panel to hear your case. You will be invited to attend the hearing, which includes an uninvolved medical director and a representative from the Appeals and Grievance Resolution Department. You may attend in person or by teleconference. After the hearing, we will send you a final resolution letter.

  If you are not satisfied with the resolution of your grievance that does not include a quality of care issue, such as waiting time, disrespect, Customer Service or cleanliness, you may contact the Blue Shield of California Medicare Rx Plan Customer Service department to request an additional review.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 7.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

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

Or

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

Section 7.4 You can also tell Medicare about your complaint

You can submit a complaint about Blue Shield of California Medicare Rx Plan directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Blue Shield of California Medicare Rx Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

When is your Plan Sponsor's Open Enrollment Period? Your Plan Sponsor will let you know when your Open Enrollment Period begins and ends, what plan choices are available to you, and the effective date of coverage. In addition to your Plan Sponsor's Open Enrollment Period, you may also make a change to your health coverage during the Annual Enrollment Period from October 15 to December 7. If you elect to enroll in a product that has a prescription drug plan, you will be disenrolled from this plan.

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

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Blue Shield of California Medicare Rx Plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples; For the full list you can contact our plan, call Medicare, or visit the Medicare.gov:

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE) (PACE is not available in all states. If you would like to know if PACE is available in your state, call Customer Service at **(800) 542-8364** (TTY users call **711**).)
- **Note**: If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D drug coverage.
    - If you enroll in most Medicare health plans, you'll automatically be disenrolled from Blue Shield of California Medicare Rx Plan when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep Blue Shield of California Medicare Rx Plan for your drug coverage. If you don't want to keep our plan, you can choose

to enroll in another Medicare prescription drug plan or to drop Medicare drug coverage.

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

Your membership will usually end on the first day of the month after we get your request to change your plan.

If you get Extra Help from Medicare to pay your drugs coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.3 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at (800) 542-8364 (TTY users call 711)**
- **Please reach out to your Plan Sponsor for more information about terminating your plan.**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan. Reach out to your Plan Sponsor prior to making any changes.

To switch from our plan to:	Here's what to do:
A Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Blue Shield of California Medicare Rx Plan and CCPOA Medical Plan Medicare (PPO) when your new plan's coverage starts.
Original Medicare *with* a different Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Blue Shield of California Medicare Rx Plan and CCPOA Medical Plan Medicare (PPO) when your new drug plan's coverage starts.

Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Call Customer Service at **(800) 542-8364** (TTY users call **711**) if you need more information on how to do this. • Please reach out to your Plan Sponsor for more information about terminating your plan. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Blue Shield of California Medicare Rx Plan and CCPOA Medical Plan Medicare (PPO) when your coverage in Original Medicare starts.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

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

- **Continue to use our network pharmacies And/or home delivery to get your prescriptions filled.**

SECTION 5 Blue Shield of California Medicare Rx Plan must end your plan membership in certain situations

Blue Shield of California Medicare Rx Plan must end your membership in our plan if any of the following happen:

- If we are notified that you no longer meet the eligibility requirements of your Plan Sponsor
- If your Plan Sponsor's contract with us is terminated
- If you no longer have either Medicare Part A or Part B.
- If you move out of our service area.
- If you're away from our service area for more than 12 months.
    - If you move or take a long trip, call Customer Service at **(800) 542-8364** (TTY users call **711**) to find out if the place you're moving or traveling to is in our plan's area.

- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Service at **(800) 542-8364** (TTY users call **711**).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Blue Shield of California Medicare Rx Plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Customer Service at **(800) 542-8364** (TTY users call **711**). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Administration of the *Evidence of Coverage*

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

SECTION 5 Member cooperation

You must complete any applications, forms, statements, releases, authorizations, lien forms and any other documents that we request in the normal course of business or as specified in this *Evidence of Coverage*.

SECTION 6 Assignment

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

SECTION 7 Employer responsibility

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

SECTION 8 Government agency responsibility

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

SECTION 9 U.S. Department of Veterans Affairs

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

SECTION 10 Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits under workers' compensation or employer's liability law. We will provide covered Part D drugs even if it is unclear whether you are entitled to benefits, but we may recover the value of any Covered Services from the following sources:

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

SECTION 11 Overpayment recovery

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

SECTION 12 When a third party causes your injuries

If you are injured or becomes ill due to the act or omission of another person (a third party), Blue Shield shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for Services provided to you from any recovery (defined below) obtained by or on behalf of you, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery you receive as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the Recovery), without regard to whether you have been made whole by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

You are required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which you expect to bring or has brought against the third party arising from the alleged acts or

omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a lien calculated in accordance with the California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

Your failure to comply with 1. through 5., above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

SECTION 13 Reporting Fraud, Waste, and Abuse

What is fraud, waste, and abuse (FWA)?

- **Fraud** is an intentional misrepresentation that may result in unauthorized costs to a healthcare program.
- **Waste** is the inappropriate use of healthcare funds or resources without a justifiable need to do so.
- **Abuse** is a practice that is inconsistent with sound medical or business practices that may directly or indirectly result in unnecessary costs to a healthcare program.

Protect yourself and your benefits

- Never give out your Social Security, Medicare or health plan numbers or banking information to someone you don't know.
- Do not consent to any lab tests without your doctor's order.
- It is illegal to accept anything of value in exchange for medical services.

Be aware of genetic testing fraud

Scammers approach unsuspecting enrollees at local health fairs, senior housing facilities, community centers, home health agencies, and other trustworthy locations to carry out genetic testing fraud. They falsely promise that Medicare will pay for the test, and you simply need to provide a cheek swab, your ID, and Medicare information in order to receive your test results.

Unfortunately, now these scammers have your health plan or Medicare number, and they can bill Medicare thousands of dollars for tests or even services that you never receive. They also have your personal genetic information.

To report suspected fraud, waste, and abuse, please contact:

- **Blue Shield of California's Medicare fraud hotline: (855) 331-4894 (TTY: 711)** or via email: **MedicareStopFraud@blueshieldca.com**.

- **Medicare at 1-800 MEDICARE (1-800-633-4227),** 24 hours a day, seven days a week (TTY users should call 1-877-486-2048).

CHAPTER 10:
Definitions

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

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

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,400 for Part D covered drugs during the covered year. During this payment stage, our plan pays the full cost for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

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

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are gotten. (This is in addition to our plan's monthly premium, if applicable.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before drugs are covered; 2) any fixed copayment amount that a plan requires when a specific drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is gotten.

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're 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 our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

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

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

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

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

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

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

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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

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

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

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

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

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

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

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

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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

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

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

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

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

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

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

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

Open Enrollment Period – The time period set by the Plan Sponsor when members can change their health or drug plans or switch to Original Medicare. Please contact your Plan Sponsor for specific details.

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

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 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. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

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

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan. PACE is not available in all states. If you would like to know if PACE is available in your state, call Customer Service at **(800) 542-8364** (TTY users call **711**).

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

Plan Sponsor - CCPOA

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

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

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

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug 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.

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

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren’t the same as Social Security benefits.

EXHIBIT 1: State Health Insurance Assistance Programs (SHIP) – Contact Information

Alabama | State Health Insurance Assistance Program (SHIP) 201 Monroe St., RSA Tower, Suite 350, Montgomery, AL 36130 https://alabamaageline.gov/	1-800-243-5463 TTY 711
Alaska | Medicare Information Office – Alaska Department of Health & Social Services 400 Gambell St., Suite 303, Anchorage, AK 99501 https://health.alaska.gov/en/senior-and-disabilities-services/medicare-office/	1-800-478-6065 TTY 711
Arizona | State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson, Site Code MD6288, Phoenix, AZ 85007 https://azship.org/	1-800-432-4040 TTY 711
Arkansas | Senior Health Insurance Information Program (SHIIP) #1 Commerce Way, Suite 102, Little Rock, AR 72202 https://insurance.arkansas.gov/consumer-assistance/medicare-resources/shiip/	1-800-224-6330 TTY 711
California | Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Dr., Suite 200, Sacramento, CA 95834 https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/	1-800-434-0222 TTY 711
Colorado | Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, Suite 850, Denver, CO 80202 https://doi.colorado.gov/types-of-insurance/health-insurance/senior-health-care-medicare	1-888-696-7213 TTY 711
Connecticut | Connecticut Health Insurance Assistance, Outreach, Information and Referral, Counseling, and Eligibility Screening (CHOICES) 55 Farmington Ave., 12th Floor, Hartford, CT 06105 https://portal.ct.gov/ads/programs-and-services/choices	1-800-994-9422 TTY 711
Delaware | Delaware Medicare Assistance Bureau 1351 W. North St., Suite 101, Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711

District of Columbia | DC SHIP 500 K St. NE, Washington, DC 20002 https://dacl.dc.gov/service/health-insurance-counseling	1-202-727-8370 TTY 711
Florida | Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Suite 280-S, Tallahassee, FL 32399 https://www.floridashine.org/	1-800-963-5337 TTY 711
Georgia | Georgia SHIP 2 Peachtree St. NW, Suite 33-101, Atlanta, GA 30303 https://aging.georgia.gov/georgia-ship	1-866-552-4464 TTY 711
Guam | Guam Medicare Assistance Program (GUAM MAP) 130 University Dr., University Castle Mall, Mangilao, GU 96913 https://dphss.guam.gov/	1-671-735-7415 TTY 711
Hawaii | Hawaii SHIP 250 S. Hotel St., Suite 406, Honolulu, HI 96813 https://www.hawaiiship.org/	1-888-875-9229 TTY 711
Idaho | Senior Health Insurance Benefits Advisors (SHIBA) 700 W. State St., 3rd Floor, Boise, ID 83720 https://doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711
Illinois | Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100, Springfield IL 62702 https://ilaging.illinois.gov/ship	1-800-252-8966 TTY 711
Indiana | State Health Insurance Assistance Program (SHIP) 311 W. Washington St., 2nd Floor, Indianapolis, IN 46204 https://www.in.gov/ship/	1-800-452-4800 TTY 711
Iowa | Senior Health Insurance Information Program (SHIIP) Two Ruan Center, 601 Locust, 4th Floor, Des Moines, IA 50309 https://shiip.iowa.gov/	1-800-351-4664 TTY 711
Kansas | Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Ave., Topeka, KS 66603 https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick	1-800-860-5260 TTY 711
Kentucky | State Health Insurance Assistance Program (SHIP) 275 E. Main St., 3E-E, Frankfort, KY 40621 https://www.chfs.ky.gov/agencies/dail/Pages/ship	1-877-293-7447 TTY 711
Louisiana | Senior Health Insurance Information Program (SHIIP) P.O. Box 94214, Baton Rogue, LA 70804 https://www.ldi.la.gov/consumers/senior-health-shiip	1-800-259-5300 TTY 711
Maine | State Health Insurance Assistance Program (SHIP) 109 Capitol St., 11 State House Station, Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	1-800-262-2232 TTY 711

Maryland | State Health Insurance Assistance Program (SHIP) 301 W. Preston St., Room 1007, Baltimore, MD 21201 https://aging.maryland.gov/programs-and-services/medicare-support/state-health-insurance-assistance-program	1-800-243-3425 TTY 711
Massachusetts | Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton Pl., 5th Floor, Boston, MA 02108 https://www.mass.gov/orgs/executive-office-of-aging-independence-age	1-800-243-4636 TTY 711
Michigan | MI Options 400 S. Pine St., 6th Floor, Lansing, MI 48913 https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program	1-800-803-7174 TTY 711
Minnesota | State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar St., P.O. Box 64976, St. Paul, MD 55164 https://mn.gov/aging-pathways/medicare/	1-800-333-2433 TTY 711
Mississippi | State Health Insurance Assistance Program (SHIP) 750 N. State St., Jackson, MS 39202 https://www.mdhs.ms.gov/post/navigating-medicare-made-easy-with-ship	1-844-822-4622 TTY 711
Missouri | Missouri SHIP 601 W. Nifong Blvd., Suite 3A, Columbia, MO 65203 https://www.missouriship.org	1-800-390-3330 TTY 711
Montana | State Health Insurance Assistance Program (SHIP) P.O. Box 4210, Helena, MT 59604 https://dphhs.mt.gov/sltc/aging/ship	1-406-444-4077 TTY 711
Nebraska | Nebraska SHIP P.O. Box 95087, Lincoln, NE 68509 https://doi.nebraska.gov/nebraska-ship-smp	1-800-234-7119 TTY 711
Nevada | Nevada Medicare Assistance Program (MAP) 3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102 https://www.adsd.nv.gov/programs/aging-services-medicare-assistance-program	1-800-307-4444 TTY 711
New Hampshire | NH SHIP – ServiceLink Resource Center 105 Pleasant St., Gov. Gallan State Office Park South, Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers	1-866-634-9412 TTY 711
New Jersey | State Health Insurance Assistance Program (SHIP) P.O. Box 807, Trenton, NJ 08625 https://www.nj.gov/humanservices/doas/services/q-z/ship/	1-800-792-8820 TTY 711

New Mexico | New Mexico ADRC-SHIP 2550 Cerrillos Rd., Santa Fe, NM 87505 https://www.aging.nm.gov/consumer-and-elder-rights/medicare/ship-and-smp-volunteer-program/	1-800-432-2080 TTY 711
New York | Health Insurance Information Counseling and Assistance Program (HIICAP) Two Empire State Plaza Agency Building #2 https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs	1-800-701-0501 TTY 711
North Carolina | Seniors' Health Insurance Information Program (SHIIP) 1201 Mail Service Center, Raleigh, NC 27699 https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip	1-855-408-1212 TTY 711
North Dakota | Senior Health Insurance Counseling (SHIC) 600 East Blvd., Department 401, Bismarck, ND 58505 https://www.insurance.nd.gov/consumers/medicare	1-888-575-6611 TTY 711
Ohio | Ohio Senior Health Insurance Information Program (OSHIIP) 50 W. Town St., 3rd Floor, Suite 300, Columbus, OH 43215 https://insurance.ohio.gov/consumers/medicare/01-oshiip	1-800-686-1578 TTY 711
Oklahoma | Oklahoma Medicare Assistance Program (MAP) 400 NE 50th St., Oklahoma City, OK 73105 https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/	1-800-763-2828 TTY 711
Oregon | Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St. NE, Room 330, Salem, OR 97309 https://shiba.oregon.gov	1-800-722-4134 TTY 711
Pennsylvania | Pennsylvania Medicare Education and Decision Insight (PA MEDI) 555 Walnut St., 5th Floor, Harrisburg, PA 17109 https://www.pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling	1-800-783-7067 TTY 711
Puerto Rico | State Health Insurance Assistance Program (SHIP) P.O. Box 191179, San Juan, PR 00919 https://www.oppea.pr.gov/programas-y-servicios	1-877-725-4300 TTY 711
Rhode Island | Senior Health Insurance Program (SHIP) 25 Howard Ave., Building 57, Cranston, RI 02920 https://oha.ri.gov/Medicare	1-888-884-8721 TTY 711

South Carolina | Insurance Counseling Assistance and Referrals for Elders (I-CARE) 1301 Gervais St., Suite 350, Columbia, SC 29201 https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud	1-800-868-9095 TTY 711
South Dakota | Senior Health Insurance & Insurance Education (SHIINE) 700 Governors Dr., Pierre, SD 57501 https://dhs.sd.gov/en/ltss/shiine	1-800-536-8197 TTY 711
Tennessee | TN SHIP Andrew Jackson Bldg., 502 Deaderick St., 9th Floor, Nashville, TN 37243 https://tnmedicarehelp.com	1-877-801-0044 TTY 711
Texas | Department of Aging and Disability Services (HICAP) 701 W. 51st St., MC: W275, Austin, TX 78751 https://www.hhs.texas.gov/services/health/medicare	1-800-252-9240 TTY 711
U.S. Virgin Islands | Virgin Islands State Health Insurance Assistance Program (VISHIP) 4007 Estate Diamond Ruby, 1st Floor, Cristiansted, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-344-774-2991 TTY 711
Utah | Senior Health Insurance Information Program (SHIP) 195 N. 1950 West, Salt Lake City, UT 84116 https://daas.utah.gov/seniors/	1-800-541-7735 TTY 711
Vermont | State Health Insurance Assistance Program 476 Main St., Suite 3, Winooski, VT 05404 https://vermont4a.org/medicare-information	1-800-642-5119 TTY 711
Virginia | Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Ave., Henrico, VA 23229 https://dars.virginia.gov/aging/home-community/medicare-counseling/	1-800-552-3402 TTY 711
Washington | Statewide Health Insurance Benefits Advisor (SHIBA) 5000 Capitol Blvd., Tumwater, WA 98504 https://www.insurance.wa.gov/insurance-resources/medicare/get-free-medicare-help-shiba	1-800-562-6900 TTY 711
West Virginia | West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East, 3rd Floor Town Center Mall, Charleston, WV 25305 http://www.wvship.org/	1-877-987-4463 TTY 711

Wisconsin | WI State Health Insurance Assistance Program (SHIP) 1 W. Wilson St., Room 551, P.O. Box 7851, Madison, WI 53707 https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling	1-800-242-1060 TTY 711
Wyoming | Wyoming State Health Insurance Information Program (WSHIIP) 106 W. Adams Ave., Riverton, WY 82501 https://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	1-800-856-4398 TTY 711

EXHIBIT 2: Quality Improvement Organizations (QIO) – Contact Information

Alabama | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Alaska | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com https://www.commencehealthqio.cms.gov	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
American Samoa | Commence Health BFCC-QIO Program BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Arizona | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Arkansas | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
California | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Colorado | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Connecticut | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Delaware | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

District of Columbia | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Florida | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Georgia | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Guam | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Hawaii | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Idaho | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Illinois | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Indiana | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Iowa | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Kansas | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

Kentucky | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Louisiana | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Maine | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Maryland | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Massachusetts | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Michigan | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Minnesota | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Mississippi | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Missouri | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Montana | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays

Nebraska | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Nevada | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
New Hampshire | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
New Jersey | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
New Mexico | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
New York | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
North Carolina | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
North Dakota | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Northern Mariana Islands | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Ohio | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

Oklahoma | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Oregon | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Pennsylvania | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Puerto Rico | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Rhode Island | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
South Carolina | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
South Dakota | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Tennessee | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Texas | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
U.S. Virgin Islands | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

Utah | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Vermont | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Virginia | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Washington | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
West Virginia | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Wisconsin | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Wyoming | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays

EXHIBIT 3: Medicaid – Contact Information

Alabama | Alabama Medicaid https://medicaid.alabama.gov/	1-800-362-1504 TTY 711
Alaska | Department of Health, Division of Public Assistance (DPA) Services https://health.alaska.gov/en/services/division-of-public-assistance-dpa-services/	1-800-478-7788 TTY 711
American Samoa | American Samoa Medicaid Agency https://www.asmsa.gov	1-684-699-4777 TTY 711
Arizona | Arizona Health Care Cost Containment System (AHCCCS) https://www.azahcccs.gov	1-855-432-7587 TTY 711
Arkansas | Arkansas Medicaid https://humanservices.arkansas.gov/divisions-shared-services/medical-services/contact-dms-2/	1-800-482-5431 TTY 711
California | Department of Health Care Services https://www.dhcs.ca.gov/services/medi-cal-resources/medi-cal-contacts/	1-800-541-5555 TTY 711
Colorado | Health First Colorado https://hcpf.colorado.gov/	1-800-221-3943 TTY 711
Connecticut | Connecticut Medicaid https://www.huskyhealthct.org	1-800-859-9889 TTY 711
Delaware | Delaware Medicaid & Medical Assistance https://dhss.delaware.gov/dmma/	1-866-843-7212 TTY 711
District of Columbia | DC Medicaid https://districtdirect.dc.gov	1-855-532-5465 TTY 711
Florida | Agency for Health Care Administration https://ahca.myflorida.com/medicaid/Information	1-877-254-1055 TTY 711
Georgia | Georgia Medicaid https://dch.georgia.gov/	1-866-211-0950 TTY 711
Guam | Department of Public Health & Social Services (DPHSS) https://dphss.guam.gov/	1-877-548-7669 TTY 711
Hawaii | Department of Human Services https://medquest.hawaii.gov/	1-800-316-8005 TTY 711
Idaho | Department of Health & Welfare https://healthandwelfare.idaho.gov/	1-877-456-1233 TTY 711
Illinois | Department of Healthcare and Family Services https://hfs.illinois.gov/medicalclients	1-800-843-6154 TTY 711
Indiana | Indiana Family and Social Services Administration https://www.in.gov/fssa/dfr/medicaid-health-plans/	1-800-403-0864 TTY 711

Iowa | Department of Human Services https://hhs.iowa.gov/medicaid	1-800-338-8366 TTY 711
Kansas | KanCare https://www.kancare.ks.gov/	1-800-792-4884 TTY 711
Kentucky | Kentucky Cabinet for Health and Family Services https://www.chfs.ky.gov/agencies/dms	1-888-317-0751 TTY 711
Louisiana | Healthy Louisiana https://ldh.la.gov	1-888-342-6207 TTY 711
Maine | Department of Health and Human Services https://www.maine.gov/dhhs/oms	1-855-797-4357 TTY 711
Maryland | Department of Health https://health.maryland.gov/mmcp	1-855-642-8572 TTY 711
Massachusetts | MassHealth https://www.mass.gov/topics/masshealth	1-800-841-2900 TTY 711
Michigan | Department of Health & Human Services https://www.michigan.gov/mdhhs/assistance-programs/medicaid	1-833-599-6444 TTY 711
Minnesota | Department of Human Services https://mn.gov/dhs/	1-800-657-3672 TTY 711
Mississippi | Division of Medicaid https://medicaid.ms.gov/medicaid-coverage/	1-800-421-2408 TTY 711
Missouri | Department of Social Services https://dss.mo.gov/	1-800-348-6627 TTY 711
Montana | Department of Public Health and Human Services https://dphhs.mt.gov	1-800-362-8312 TTY 711
Nebraska | Department of Health and Human Services https://dhhs.ne.gov	1-855-632-7633 TTY 711
Nevada | Department of Health and Human Services https://www.dhs.nv.gov/find-assistance/medical-assistance/	1-877-638-3472 TTY 711
New Hampshire | Department of Health and Human Services https://www.dhhs.nh.gov/programs-services/medicaid	1-844-275-3447 TTY 711
New Jersey | Department of Human Services https://www.nj.gov/humanservices/	1-800-701-0710 TTY 711
New Mexico | Human Services Department https://www.hca.nm.gov/	1-800-283-4465 TTY 711
New York | State Department of Health https://info.nystateofhealth.ny.gov/	1-855-355-5777 TTY 711
North Carolina | North Carolina Medicaid https://medicaid.ncdhhs.gov/	1-888-245-0179 TTY 711
North Dakota | Department of Human Services https://www.hhs.nd.gov/applyforhelp	1-800-755-2604 TTY 711
Northern Mariana Islands | Commonwealth Medicaid Agency https://www.cnmimedicaid.org	1-670-664-4880 TTY 711

Ohio | Department of Medicaid https://medicaid.ohio.gov/	1-800-324-8680 TTY 711
Oklahoma | Oklahoma Health Care Authority https://oklahoma.gov/ohca.html	1-800-987-7767 TTY 711
Oregon | OregONEligibility https://one.oregon.gov/	1-800-699-9075 TTY 711
Pennsylvania | Department of Human Services https://www.pa.gov/agencies/dhs	1-800-692-7462 TTY 711
Puerto Rico | Government of Puerto Rico https://www.medicaid.pr.gov/	1-787-641-4224 TTY 711
Rhode Island | Executive Office of Health and Human Services https://eohhs.ri.gov/	1-855-840-4774 TTY 711
South Carolina | Health Connections Medicaid https://www.scdhhs.gov/	1-888-549-0820 TTY 711
South Dakota | Department of Social Services https://dss.sd.gov/medicaid/	1-800-597-1603 TTY 711
Tennessee | Department of Health https://www.tn.gov/tenncare	1-855-259-0701 TTY 711
Texas | Health and Human Services https://www.hhs.texas.gov/services/health/medicaid-chip	1-800-335-8957 TTY 711
U.S. Virgin Islands | Department of Human Services https://dhs.vi.gov/office-of-medicaid/	1-340-715-6929 TTY 711
Utah | Department of Health - Medicaid https://medicaid.utah.gov/	1-866-435-7414 TTY 711
Vermont | Vermont Health Connect https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action	1-855-899-9600 TTY 711
Virginia | Department of Medical Assistance Services https://www.dmas.virginia.gov/	1-833-522-5582 TTY 711
Washington | Washington State Health Care Authority https://www.hca.wa.gov/	1-800-562-3022 TTY 711
West Virginia | Department of Health and Human Services https://dohs.wv.gov/	1-877-716-1212 TTY 711
Wisconsin | Department of Health Services https://www.dhs.wisconsin.gov/	1-800-362-3002 TTY 711
Wyoming | Department of Healthcare Financing https://health.wyo.gov/healthcarefin/medicaid/	1-855-294-2127 TTY 711

EXHIBIT 4: State Pharmaceutical Assistance Programs (SPAP)

Alabama | Alabama AIDS Drug Assistance Program https://www.alabamapublichealth.gov/hiv/	1-334-206-5853 TTY 711
Arizona | Arizona AIDS/HIV Drug Assistance Program (ADAP) Assist https://www.azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/?index.php#aids-drug-assistance-program-home	1-480-258-1069 TTY 711
Arkansas| Arkansas Ryan White Part B/ADAP Program https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/	1-501-661-2862 TTY 711
California | California Department of Public Health, Office of AIDS, AIDS Drug Assistance Program https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	1-844-421-7050 TTY 711
Colorado | Bridging the Gap Colorado – also Ryan White Part B https://cdphe.colorado.gov/state-drug-assistance-program	1-303-692-2716 TTY 711
Connecticut | CT ADAP https://ctdph.primetherapeutics.com	1-800-424-3310 TTY 711
Delaware | Delaware Prescription Assistance Program https://dchealth.dc.gov/Pharmacy_Benefits_Program	1-302-744-1050 TTY 711
District of Columbia | DC ADAP https://dchealth.dc.gov/Pharmacy_Benefits_Program	1-202-671-4810 TTY 711
Florida | AIDS Drug Assistance Program https://www.floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management/	1-850-901-6677 TTY 711
Georgia | Georgia AIDS Drug Assistance Program https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap	1-404-656-9805 TTY 711
Idaho | IDAGAP https://healthandwelfare.idaho.gov/	1-208-334-6526 TTY 711
Illinois | Illinois AIDS Drug Assistance Program https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids	1-217-524-5983 TTY 711
Indiana | HIV Service Program https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/	1-317-234-1811 TTY 711
Indiana | HoosierRx https://www.in.gov/medicaid/members/member-programs/hoosierrx/	1-866-267-4679 TTY 711

Iowa | Iowa Health and Human Services, Benefits and Drug Assistance Program https://hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program	1-515-204-3746 TTY 711
Kansas | Kansas ADAP https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program	1-785-213-9546 TTY 711
Kentucky | Kentucky ADAP https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-866-510-0005 TTY 711
Louisiana | Louisiana Health Access Program https://lahap.org/	1-504-568-7474 TTY 711
Maine | The Low Cost Drug Program for the Elderly and Disabled https://www.maine.gov/dhhs/ofi/programs-services	1-866-796-2463 TTY 711
Maryland | Maryland AIDS Drug Assistance Program https://health.maryland.gov/phpa/IDPHSB/Pages/MADAP.aspx	1-410-767-6535 TTY 711
Maryland | Maryland Senior Prescription Drug Assistance Program https://marylandspdap.com/	1-800-551-5995 TTY 711
Massachusetts | EOHHS SPAP https://www.payingforseniorcare.com/massachusetts/prescription-advantage-program	1-800-841-2900 TTY 711
Massachusetts | Prescription Advantage https://www.mass.gov/info-details/prescription-advantage-documents-and-resources	1-800-243-4636 TTY 711
Michigan | Michigan Drug Assistance Program https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program	1-517241-3912 TTY 711
Minnesota | Department of Human Services https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/hiv-aids/programs-services/	1-844-575-7887 TTY 711
Mississippi | MS ADAP https://msdh.ms.gov/	1-601-362-4879 TTY 711
Missouri | MORx https://mydss.mo.gov/mhd/morx-general-faqs	1-573-751-6963 TTY 711
Montana | State of Montana HIV Treatment Program https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog	1-406-444-4744 TTY 711
Nevada | Nevada Medication Assistance Program https://www.ramsellcorp.com/individuals/nv.aspx	1-888-311-7632 TTY 711
New Hampshire | New Hampshire AIDS Drug Assistance Program (ADAP) https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids	1-603-271-4502 TTY 711
New Jersey | New Jersey AIDS Drug Distribution Program (NJADDP) https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533 TTY 711

New Jersey | New Jersey Senior Gold Discount Card Program https://www.nj.gov/humanservices/doas/services/q-z/senior-gold/	1-800-792-9745 TTY 711
New Mexico | New Mexico Medical Insurance Pool https://nmmip.org/	1-844-728-7896 TTY 711
New York | NYS EPIC https://www.health.ny.gov/health_care/epic/	1-800-332-3742 TTY 711
New York | NYS Uninsured Care Programs https://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm	1-518-459-1641 TTY 711
North Carolina | North Carolina SPAP https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	1-984-236-4128 TTY 711
North Dakota | North Dakota AIDS Drug Assistance Program (ADAP) https://www.hhs.nd.gov/health/diseases-conditions-and-immunization/HIV/LivingwithHIV/RyanWhite	1-701-328-2379 TTY 711
Ohio | Ohio AIDS Drugs Assistance Program (ADAP) https://odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/	1-800-777-4775 TTY 711
Oregon | CAREAssist Program https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/Pages/index.aspx	1-971-673-0144 TTY 711
Pennsylvania | Special Pharmaceutical Benefits Program/ADAP https://www.pa.gov/agencies/health/diseases-conditions/infectious-disease/hiv/special-pharmaceutical-benefits	1-800-922-9384 TTY 711
Puerto Rico | Puerto Rico Ryan White Part B/ADAP https://www.salud.pr.gov/	1-787-765-2929 TTY 711
Rhode Island | Rhode Island State Pharmaceutical Assistance to the Elderly https://oha.ri.gov/resources/health-insurance-health-care-cost-assistance/drug-cost-assistance	1-401-462-0560 TTY 711
South Carolina | South Carolina AIDS Drug Assistance Program (HIV+) https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	1-800-856-9954 TTY 711
South Dakota | Ryan White Part B Program https://doh.sd.gov/topics/diseases/disease-prevention-services/hivaids/ryan-white-part-b-program/	1-800-592-1861 TTY 711
Tennessee | Ryan White Part B Program https://www.tn.gov/health/rwb.html	1-800-525-2437 TTY 711
Texas | TX THMP SPAP Program https://www.dshs.texas.gov/hivstd/meds/spap	1-800-255-1090 TTY 711
Utah | Utah ADAP https://epi.utah.gov/ryan-white/	1-801-518-1303 TTY 711

Vermont | State Pharmaceutical Assistance Program for State of Vermont https://dvha.vermont.gov/members/prescription-assistance	1-800-250-8427 TTY 711
Virginia | Virginia State Pharmaceutical Assistance Program https://www.vdh.virginia.gov/disease-prevention/vamap/	1-855-362-0658 TTY 711
Washington | Early Intervention Program https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program	1-877-376-9316 TTY 711
Wisconsin | Wisconsin HIV Drug Assistance Program https://www.dhs.wisconsin.gov/hiv/hdap.htm	1-800-991-5532 TTY 711
Wisconsin | SeniorCare https://www.dhs.wisconsin.gov/seniorcare/index.htm	1-608-267-7813 TTY 711
Wyoming | WDH Communicable Disease Treatment Program https://health.wyo.gov/publichealth/communicable-disease-unit/hiv/	1-307-777-6563 TTY 711

EXHIBIT 5: AIDS Drug Assistance Programs (ADAP) – Contact Information

Alabama | Alabama AIDS Drug Assistance Program https://www.alabamapublichealth.gov/hiv/	1-800-252-1818 TTY 711
Alaska | Alaskan AIDS Assistance Association https://www.alaskanaids.org/client-services/aids-drug-assistance-program-adap	1-800-478-2437 TTY 711
Arizona | Arizona AIDS/HIV Drug Assistance Program (ADAP) https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home	1-800-334-1540 TTY 711
Arkansas| Arkansas Ryan White Part B/ADAP Program https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/	1-501-661-2862 TTY 711
California | California Department of Public Health, Office of AIDS, AIDS Drug Assistance Program https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	1-844-421-7050 TTY 711
Colorado | Bridging the Gap Colorado – also Ryan White Part B https://cdphe.colorado.gov/state-drug-assistance-program	1-303-692-2716 TTY 711
Connecticut | CT ADAP https://ctdph.primetherapeutics.com	1-800-424-3310 TTY 711
Delaware | Delaware Prescription Assistance Program https://dchealth.dc.gov/Pharmacy_Benefits_Program	1-302-744-1050 TTY 711
District of Columbia | DC Pharmacy Benefits Program https://dchealth.dc.gov/Pharmacy_Benefits_Program	1-202-671-4815 TTY 711
Florida | Ryan White Part B AIDS Drug Assistance Program https://www.floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management/	1-841-381-2327 TTY 711
Georgia | Georgia AIDS Drug Assistance Program https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap	1-404-656-9805 TTY 711
Guam | Ryan White Part B AIDS Drugs Assistance Program https://dphss.guam.gov/	1-671-735-3603 TTY 711
Hawaii | HIV Drug Assistance Program https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/	1-808-733-9360 TTY 711
Idaho | IDAGAP https://healthandwelfare.idaho.gov/	1-208-334-6526 TTY 711

Illinois | Illinois AIDS Drug Assistance Program https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids	1-217-524-5983 TTY 711
Indiana | HIV Service Program https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/	1-317-234-1811 TTY 711
Iowa | Iowa Health and Human Services, Benefits and Drug Assistance Program https://hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program	1-515-204-3746 TTY 711
Kansas | Kansas ADAP https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program	1-785-213-9546 TTY 711
Kentucky | Kentucky ADAP https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-866-510-0005 TTY 711
Louisiana | Louisiana Health Access Program https://lahap.org/	1-504-568-7474 TTY 711
Maine | Ryan White Part B Program https://www.maine.gov/dhhs/mecdc/diseases-conditions/sexually-transmitted-diseases/hiv-aids/ryan-white	1-207-287-3747 TTY 711
Maryland | Maryland AIDS Drug Assistance Program https://health.maryland.gov/phpa/IDPHSB/Pages/MADAP.aspx	1-410-767-6535 TTY 711
Massachusetts | Community Resource Initiative - HDAP https://crihealth.org/drug-assistance/hdap/	1-617-502-1793 TTY 711
Michigan | Michigan Drug Assistance Program https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program/michigan-drug-assistance-program	1-517-241-3912 TTY 711
Minnesota | Department of Human Services https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/hiv-aids/programs-services/	1-844-575-7887 TTY 711
Mississippi | MS ADAP https://msdh.ms.gov/	1-601-362-4879 TTY 711
Missouri | Ryan White Part B Program https://health.mo.gov/conditions-diseases/communicable-diseases/hiv-stis-hepatitis/hiv-aids/care-case-management	1-573-751-6963 TTY 711
Montana | State of Montana HIV Treatment Program https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog	1-406-444-4744 TTY 711
Nebraska | Ryan White Part B Program https://dhhs.ne.gov/Pages/HIV-Care.aspx	1-402-471-3121 TTY 711
Nevada | Ryan White Part B Program https://endhivnevada.org/ryan-white-care/	1-702-486-0768 TTY 711
New Hampshire | New Hampshire AIDS Drug Assistance Program (ADAP) https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids	1-603-271-4502 TTY 711

New Jersey | New Jersey AIDS Drug Distribution Program (NJADDP) https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533 TTY 711
New Mexico | New Mexico HIV Services Network https://www.nmhealth.org/about/phd/idb/hats/	1-833-796-8773 TTY 711
New York | Uninsured Care Programs https://www.health.ny.gov/diseases/aids/general/resources/adap/	1-800-542-2437 TTY 711
North Carolina | North Carolina HIV Medication Assistance Program https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	1-877-466-2232 TTY 711
North Dakota | North Dakota AIDS Drug Assistance Program (ADAP) https://www.hhs.nd.gov/health/diseases-conditions-and-immunization/HIV/LivingwithHIV/RyanWhite	1-701-328-2379 TTY 711
Northern Mariana Islands | Ryan White Part B Program https://phs.chcc.health/hiv-sti-program/	1-670-664-4050 TTY 711
Ohio | Ohio AIDS Drugs Assistance Program (ADAP) https://odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/	1-800-777-4775 TTY 711
Oklahoma | HIV Drug Assistance Program (HDAP) https://oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.html	1-405-426-8400 TTY 711
Oregon | CAREAssist Program https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/Pages/index.aspx	1-971-673-0144 TTY 711
Pennsylvania | Special Pharmaceutical Benefits Program/ADAP https://www.pa.gov/agencies/health/diseases-conditions/infectious-disease/hiv/special-pharmaceutical-benefits	1-800-922-9384 TTY 711
Puerto Rico | Puerto Rico Ryan White Part B/ADAP https://www.salud.pr.gov/	1-787-765-2929 TTY 711
Rhode Island | Ryan White Part B Program https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	1-401-462-0560 TTY 711
South Carolina | South Carolina AIDS Drug Assistance Program (HIV+) https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	1-800-856-9954 TTY 711
South Dakota | Ryan White Part B Program https://doh.sd.gov/topics/diseases/disease-prevention-services/hivaids/ryan-white-part-b-program/	1-800-592-1861 TTY 711
Tennessee | Ryan White Part B Program https://www.tn.gov/health/rwb.html	1-800-525-2437 TTY 711
Texas | Texas HIV Medication Program https://www.dshs.texas.gov/hivstd/meds	1-800-255-1090 TTY 711
U.S. Virgin Islands | Department of Human Services https://doh.vi.gov/programs/communicable-diseases/	1-340-774-9000 TTY 711
Utah | Ryan White Part B Program https://epi.utah.gov/ryan-white/	1-801-518-1303 TTY 711

Vermont | Vermont Medication Assistance Program (VMAP) https://www.healthvermont.gov/disease-control/sexual-health-and-sexually-transmitted-infections/hiv-treatment-and-care	1-802-951-4005 TTY 711
Virginia | Ryan White Part B Program https://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/rwhap-b/	1-855-362-0658 TTY 711
Washington | Early Intervention Program https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program	1-877-376-9316 TTY 711
West Virginia | Ryan White Part B Program https://oeps.wv.gov/ryan-white-program	1-304-232-6822 TTY 711
Wisconsin | Wisconsin HIV Drug Assistance Program https://www.dhs.wisconsin.gov/hiv/hdap.htm	1-800-991-5532 TTY 711
Wyoming | WDH Communicable Disease Treatment Program https://health.wyo.gov/publichealth/communicable-disease-unit/hiv/	1-307-777-6563 TTY 711

Blue Shield of California Medicare Rx Plan Customer Service

Method	Customer Service – Contact Information
Call	**(800) 542-8364** Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. Customer Service **(800) 542-8364** (TTY users call **711**) also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number, and the time you called, and a representative will return your call no later than one business day.
Fax	(877) 251-6671
Write	Blue Shield of California Medicare Rx Plan P.O. Box 927, Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/ccpoa**

State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. You can call the SHIP in your state at the number listed in **Exhibit 1** at the end of the *Evidence of Coverage*.

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

blueshieldca.com/medicare

Blue Shield of California 6300 Canoga Avenue, Woodland Hills, CA 91367-2555