Department of Civil Service
The Empire Plan

SilverScript Insurance Company
Empire Plan Medicare Rx
P.O. Box 30006, Pittsburgh, PA 15222-0330

January 1, 2026 - December 31, 2026

Evidence of Coverage for 2026

Your Medicare Drug Coverage as a Member of Empire Plan Medicare Rx sponsored by New York State Health Insurance Program (NYSHIP)

This document gives the details of your Medicare drug coverage from **January 1, 2026 – December 31, 2026. This is an important legal document. Keep it in a safe place.**

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

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

For questions about this document, call Empire Plan Medicare Rx Customer Service at 1-877-769-7447. (TTY users call 711). Hours are 24 hours a day, 7 days a week. This call is free.

This Plan, Empire Plan Medicare Rx, is offered by SilverScript® Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means SilverScript Insurance Company. When it says "Plan" or "our Plan," it means Empire Plan Medicare Rx.)

This document is available for free in Spanish.

This information is available in a different format, including braille, large print, and audio formats. Please call Empire Plan Medicare Rx Customer Care if you need Plan information in another format.

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2027.

Y0001_S5601_EOC_CLT.NYSHIP_2026_C_9482_2632_811

OMB Approval 0938-1051 (Expires: August 31, 2026)

Our formulary and pharmacy network may change at any time. You will get notice about any changes that may affect you at least 30 days in advance.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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CHAPTER 1:
Get started as a member

SECTION 1 You are a member of Empire Plan Medicare Rx

Section 1.1 You are enrolled in Empire Plan Medicare Rx, which is a Medicare Drug Plan

IMPORTANT, please note: This prescription drug coverage is offered in conjunction with your Empire Plan coverage. If you choose a Medicare Plan other than Empire Plan Medicare Rx, your Empire Plan coverage will be canceled.

The Empire Plan requires that its Medicare-primary members be enrolled in Empire Plan Medicare Rx to remain enrolled in hospital, medical/surgical, and mental health/substance use benefits through The Empire Plan. Therefore, cancellation of your Empire Plan Medicare Rx prescription drug coverage will also cancel all of your Empire Plan benefits including hospital, medical/surgical, and mental health/substance use coverage. If you are the enrollee and have family coverage, Empire Plan benefits for you and all of your covered dependents will be terminated. If you are covered as a dependent, only your Empire Plan benefits will be terminated. The cancellation effective date of your Empire Plan benefits will be communicated to you in a letter sent by the New York State Department of Civil Service.

Empire Plan Medicare Rx 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 and explains your Empire Plan Medicare Rx prescription drug benefits. Other parts of this contract include 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 enrolled in Empire Plan Medicare Rx between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to Plans we offer each calendar year. This means we can change the costs and benefits of Empire Plan Medicare Rx after December 31, 2026. We can also choose to stop offering the Plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Empire Plan Medicare Rx 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 are eligible for membership in our Plan as long as you meet all these conditions:

- You meet the eligibility requirements of NYSHIP, the Plan sponsor.
- 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 are not considered to be living in the geographic service area, even if they are physically located in it.
- You are a United States citizen or are lawfully present in the United States.

Section 2.2 Plan service area for Empire Plan Medicare Rx

Empire Plan Medicare Rx 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 as the United States or its territories.

If you move out of our plan's United States or its territories, you cannot stay a member of this Plan. When you move, you will have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. Call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) to see if we have a Plan in your new area and the New York State Department of Civil Service–Employee Benefits Division at 1-518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands), Monday through Friday between 9 a.m. and 4 p.m. (Eastern time).

If you move or change your mailing address, it is 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 lawful presence

You must be a U.S. citizen or lawfully present in the United States or its territories to be a member of a Medicare health plan. Medicare (CMS) will notify Empire Plan Medicare Rx if you are not eligible to stay a member of our plan. Empire Plan Medicare Rx must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our Plan membership card

Use your 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 Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) right away, and we will send you a new card.

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

Section 3.2 Pharmacy Directory

The *Pharmacy Directory* (empireplanrxprogram.com) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our Plan members and charge members their appropriate cost share. Use the *Pharmacy*

Directory to find the network pharmacy you want to use. Go to Chapter 3, Section 2.4 for information on when you can use pharmacies that are not in our Plan's network.

If you do not have a *Pharmacy Directory*, you can ask for a copy by calling Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711). You can also use the pharmacy locator on our website at empireplanrxprogram.com.

Section 3.3 Drug List *(Formulary)*

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

The *Formulary* also explains if there are any rules that restrict coverage for your drugs.

We will give you a copy of the *Formulary*. To get the most complete and current information about which drugs are covered, visit empireplanrxprogram.com for the drug list or call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).

SECTION 4 Your monthly premium for Empire Plan Medicare Rx

	Your Cost in 2026
Monthly plan premium* *Your premium can be higher or lower than this amount. See Section 4.1 for details.	*Please contact NYSHIP for more information about your plan premium.*
Deductible	*Because there is no deductible for this plan, this payment stage does not apply to you.*

	Your Cost in 2026
Part D drug coverage (Go to Chapter 4 for details, including Initial Coverage and Catastrophic Coverage Stages.)	**Copayment during the Initial Coverage Stage:** **Tier 1: Generic –** *You pay $5.00 per prescription.* **Tier 2: Preferred Brand –** *You pay $30.00 per prescription.* **Tier 3: Non-Preferred Brand –** *You pay $60.00 per prescription.* Under Medicare Part D, you won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **Catastrophic Coverage Stage:** • During this payment stage, you pay nothing for your covered Part D drugs. • You can 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 Adjustment Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan Premium

The cost of Empire Plan Medicare Rx coverage is included in your Empire Plan premium. Your share of the premium depends on the contribution rate established by NYSHIP. Please contact NYSHIP for more information about the premium for this Plan (phone numbers are printed on the back cover of this booklet).

If you are *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider)*, which tells you about your drug coverage. If you do not have this insert, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) and ask for the *LIS Rider*.

In some situations, our Plan premium could be less

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

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 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website at (https://www.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

Many members are required to pay other Medicare premiums

In addition to paying the monthly Plan premium, **you must continue paying your Medicare premiums to stay a member of our Plan.** This includes any Medicare Part D IRMAA you may owe (see section 4.4 for information on IRMAA).

Please note: If you are not eligible for premium-free Part A, contact the New York State Department of Civil Service–Employee Benefits Division at 1-518-457-5754

(Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands), Monday through Friday between 9 a.m. and 4 p.m. (ET).

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 did not have Part D or other Creditable Prescription Drug Coverage. Creditable Prescription Drug Coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage.

The cost of the late enrollment penalty depends on how long you went without Part D or other Creditable Prescription Drug Coverage. You will have to pay this penalty for as long as you have Part D coverage, including if you were to change Medicare Plans (this is a Medicare penalty that will follow you from Plan to Plan). If you are required to pay a Part D late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in Creditable Prescription Drug Coverage, or how many months you were without prescription drug coverage after you became eligible.

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

You **do not** 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 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 are not creditable prescription drug coverage.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our Plan will count the number of full months you did not have. The penalty is 1% for every month that you did not have Creditable Coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- 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 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.46. This will round to $5.50. 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 will continue to pay a penalty** every month for as long as you are enrolled in a Plan that has Medicare Part D drug benefits, even if you change plans.
- If you are 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 do not have coverage after your initial enrollment period for aging into Medicare.

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

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

Section 4.4 Income-Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income-Related Monthly Adjustment Amount (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 will 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 and how to pay the amount, visit Medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans. While NYSHIP or your former employer is required to reimburse your Medicare Part B-IRMAA, you are not entitled to any reimbursement for any Part D-IRMAA costs.

If you have to pay an 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 our Plan premium, unless your monthly benefit is not enough to cover the extra amount owed. If your benefit check is not enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra IRMAA to the government. It cannot be paid with your monthly Plan premium. If you do not pay the extra IRMAA, you will lose your Medicare benefits administered through the SSA or RRB for non-payment. If you lose your Medicare benefits, you will consequently be disenrolled from the Plan. If you are disenrolled from the Plan, all other Empire Plan benefits, including hospital, medical and mental health/substance use coverage, will also terminate.**

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 at Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

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

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

SECTION 5 More information about your monthly premium

Section 5.1 Our monthly plan premium will not change during the year

We are not allowed to change our Plan's monthly Plan premium amount during the year. If the monthly Plan premium changes for next year, NYSHIP will tell you at least 15 days prior to January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of our plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, the Extra Help pays part of your monthly Plan premiums. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare does not cover. If you lose your eligibility for Extra Help during the year you will need to start paying the full monthly premium, if applicable. Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

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

The pharmacists/pharmacies 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
- You are 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 Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).

It is also important to contact Social Security and the New York State Department of Civil Service–Employee Benefits Division if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778). You can find contact information for the Employee Benefits Division in Chapter 8, Section 2.3.

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 will send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it is correct, you do not need to do anything. If the information is not correct, or if you have other coverage that is not listed, please call Empire Plan Medicare Rx at 1-877-769-7447. (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 other 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 are 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 are over 65 and you (or your spouse) 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. Please note that this does not apply to

domestic partners. Regardless of the enrollee's employment status, Medicare is primary for a domestic partner who is age 65 or older.

- 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 Empire Plan Medicare Rx contacts

For help with claims, billing, or member card questions, call or write to Empire Plan Medicare Rx. We will be happy to help you.

Empire Plan Medicare Rx – Contact Information	
Call	The Empire Plan at 1-877-769-7447 and select option 4 for the Prescription Drug Program. Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week. Empire Plan Medicare Rx 1-877-769-7447. (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. Hours of operation: 24 hours a day, 7 days a week.
Fax	1-866-552-6205
Write	SilverScript Insurance Company Prescription Drug Plans P.O. Box 30016 Pittsburgh, PA 15222-0330
Website	empireplanrxprogram.com

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 Part D Drugs – Contact Information	
Call	The Empire Plan at 1-877-769-7447 and select option 4 for the prescription drug program. Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week.
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. Hours of operation: 24 hours a day, 7 days a week.
Fax	1-855-633-7673
Write	SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department P.O. Box 52000, MC 109 Phoenix, AZ 85072-2000
Website	empireplanrxprogram.com

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 does not involve coverage or payment disputes. (If your problem is about the Plan's coverage or payment, you should look at the section above about making an appeal.) For more information on how to make a complaint about your Part D prescription drugs, go to *Chapter 7*.

Complaints– Contact Information	
Call	1-866-884-9478 Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week.
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. Hours of operation: 24 hours a day, 7 days a week.
Fax	1-724-741-7956
Write	SilverScript Insurance Company Prescription Drug Plans Grievance Department P.O. Box 14834 Lexington, KY 40512
Medicare Website	To submit a complaint about Empire Plan Medicare Rx 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 should be paid by SilverScript, 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	1-866-235-5660 Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week.
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. Hours of operation: 24 hours a day, 7 days a week.
Write	SilverScript Insurance Company Prescription Drug Plans Medicare Part D Paper Claim P.O. Box 52066 Phoenix, AZ 85072-2066
Website	empireplanrxprogram.com

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 ESRD (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. Hours of operation: 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 Empire Plan Medicare Rx.

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. Please see the Appendix at the end of this document to find the contact information for the State Health Insurance Assistance Program in your state.

SHIPs are an independent state program (not connected with any insurance company or health plan) that get money from the federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. SHIP Counselors can also help you with Medicare questions or problems, such as understanding your Medicare plan choices or answering your questions about switching your Plan.

SECTION 4 Quality Improvement Organizations (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Please see the Appendix at the end of this document to find the contact information for the Quality Improvement Organization in your state.

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

Contact your Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact your Quality

Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 a.m. to 7 p.m. (Eastern time), 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 hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m. (Eastern time), 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 items (like 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 the Medicaid agency in your state using the contact information in the Appendix 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 and drug copayments. 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 do not 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 are 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.

Documentation from the state or Social Security Administration showing your low-income subsidy level is the preferred evidence of your proper cost-sharing level. Please fax your documentation to us at 1-866-552-6205. Please include a phone number where we can contact you. If you cannot provide the documentation and need assistance, or would like additional information, contact The Empire Plan at 1-877-769-7447 and select option 4 for the Prescription Drug Program, 24 hours a day, 7 days a week. TTY users should call 711.

- SilverScript Insurance Company will accept any of the following documents as evidence:
    - A copy of your Medicaid card that includes your name and eligibility date during the period for which you believe you qualified for Extra Help;
    - Details of any call you made to verify your Medicaid status, including the date a verification call was made to the State Medicaid Agency and the name, title, and telephone number of the state staff person who verified your Medicaid status during the discrepant period;
    - A copy of a state document that confirms your active Medicaid status during the discrepant period;
    - A print-out from the state electronic enrollment file showing your Medicaid status during the discrepant period;
    - A screen-print from the state's Medicaid systems showing your Medicaid status during the discrepant period;
    - Other documentation provided by the state showing your Medicaid status during the discrepant period;

  - A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI); or
  - An "Important Information" letter from SSA confirming that the beneficiary is automatically eligible for Extra Help.
- For beneficiaries who are institutionalized and qualify for zero cost share, the following documents will be accepted as evidence of your proper cost-sharing level:
  - A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
  - A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
  - A screen-print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.
- When we get the evidence showing the right copayment level, we will update our system so you can pay the right amount when you get your next prescription, If you overpay your copayment, we will pay you back either by check or a future copayment credit. If the pharmacy did not 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 that state. Call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) if you have questions.

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 are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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

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.

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 your state-specific ADAP using the contact information in the Appendix at the end of this booklet.

State Pharmaceutical Assistance Program (SPAP)

Many states have State Pharmaceutical Assistance Programs (SPAP) that help people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide prescription drug coverage to its members.

Please see the Appendix at the end of this document to find the contact information for the SPAP in your state, if applicable.

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 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 are participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026**. To learn more about this payment option, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) or visit Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	The Empire Plan at 1-877-769-7447 Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week. Empire Plan Medicare Rx 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. Hours of operation: 24 hours a day, 7 days a week.
Fax	1-866-552-6205
Write	SilverScript Insurance Company Prescription Drug Plans P.O. Box 7 Pittsburgh, PA 15230
Website	empireplanrxprogram.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 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are *not* 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 employer/union benefits administrator or Empire Plan Medicare Rx at 1-877-769-7447. (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 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.

You can be enrolled in only one Medicare Part D Prescription Drug Plan at a time. If you enroll in another Medicare Prescription Drug Plan, or another Medicare Advantage Plan that includes Part D coverage, Medicare will cancel your enrollment in Empire Plan Medicare Rx, and you (and your dependents) will no longer have any Empire Plan coverage, including medical/surgical, hospital, mental health and substance use, and prescription drug benefits.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator 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

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

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

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, go to your *Medicare & You 2026* handbook.) The medical coverage provided by NYSHIP may cover a supply of these drugs. Your Part D prescription drugs are covered under Empire Plan Medicare Rx.

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 is valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- Your prescriptions are covered if they are filled at one of our network pharmacies or through the Plan's mail service pharmacy and may be covered if filled at out-of-network pharmacies. (Go to Section 2) or *you can fill your prescription at a network pharmacy or through the Plan's mail service pharmacy*.
- 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 mail service pharmacy

A network pharmacy is a pharmacy that has a contract with our Plan to provide your covered drugs, and you pay only your normal share of the cost. The term covered drugs means all the Part D prescription drugs that are covered on our Plan's Formulary.

Go to Section 2.4 for information about prescriptions filled at out-of-network pharmacies.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*. You can also use the pharmacy locator on our website at (empireplanrxprogram.com), and/or call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our Plan's network, you will have to find a new pharmacy in the network, or you must pay the full cost to the pharmacy and submit a paper claim form to us for any reimbursement (amount is dependent upon review of the claim). To find another pharmacy in your area, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) or use the Pharmacy Locator on our website at empireplanrxprogram.com.

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, a LTC facility (such as a nursing home) has its own

pharmacy. If you have difficulty getting Part D drugs in an LTC facility, Call Empire Plan Medicare Rx at 1-877-769-7447. (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, look in your *Pharmacy Directory* or call Empire Plan Medicare Rx at The Empire Plan phone number.

Section 2.2 Our Plan's mail service pharmacy

For certain kinds of drugs, you can use our Plan's network mail service pharmacy. Generally, the drugs provided through mail service are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through our Plan's mail service pharmacy are marked as **"NM" for not available at mail** on our Formulary. *There may be additional drugs that are not available at mail and not marked NM, including some Hepatitis B medications, post-transplant medications, and oral medications used to treat HIV. For more information, contact Empire Plan Medicare Rx at The Empire Plan phone number (phone numbers are printed on the back cover of this document).*

Our Plan's mail service pharmacy allows you to order **up to a 90-day supply.** To get order forms and information about filling your prescriptions by mail, contact Empire Plan Medicare Rx at The Empire Plan phone number (phone numbers are printed on the back cover of this document), or visit our website at empireplanrxprogram.com.

If you need to request a rush order because of a mail order delay, you may contact Empire Plan Medicare Rx at The Empire Plan phone number (phone numbers are printed on the back cover of this document) to discuss options that may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second-day or next-day delivery of your medications, you may request this from the Empire Plan Medicare Rx customer care representative for an additional charge.

Usually, a mail service pharmacy order will be delivered to you in no more than 10 days. If the mail service pharmacy expects the order to be delayed, they will contact you and help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local pharmacy.

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

Refills on mail service prescriptions. For refills, contact your pharmacy 15 days before your current prescription will run out to make sure your next order is shipped to you in time.

If you get a refill automatically by mail that you do not 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 up to 90 days of prescription 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 Formulary. (Maintenance drugs are drugs you take on a regular basis for a chronic or long-term medical condition.)

1. **Most retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

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

Generally, we will cover drugs filled at an out-of-network pharmacy. However, you must submit a paper claim to us for reimbursement (amount is dependent upon review of the claim). **Check first with Empire Plan Medicare Rx Customer Care** to see if there is a network pharmacy nearby.

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

- The prescription is for a medical emergency or urgent care.

- You are unable to get a covered prescription drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail service pharmacy (including high-cost and unique prescription drugs).
- If you are evacuated or otherwise displaced from your home because of a federal disaster or other public health emergency declaration.
- The vaccine is administered in your doctor's office.

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. If you use an out-of-network pharmacy, we may reimburse your total cost minus your cost-share amount for the drug, depending on the situation. You must submit a paper claim to be reimbursed (the amount of reimbursement is dependent upon a review of the claim). (Go to Chapter 5, Section 2 for more 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 Formulary

Section 3.1 The Formulary 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 the Empire Plan Medicare Rx Formulary are selected by the Plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Empire Plan Medicare Rx Formulary only show drugs covered under Medicare Part D.

We generally cover a drug on our Plan's Formulary 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 a drug that is **either**:

- Approved by the FDA for the diagnosis or condition for which it is prescribed, or

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

Empire Plan Medicare Rx does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Prescription drugs covered under Medicare Part B are subject to 20% coinsurance, and a claim for the reimbursement of the coinsurance is automatically submitted (crossed over) to The Empire Plan Medical/Surgical Program for reimbursement. Out-of-pocket amounts are typically reimbursed to the enrollee within four to six weeks.

The Formulary includes both brand-name and generic drugs.

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

Drug that are not on the Formulary

Our Plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare Plan to cover certain types of drugs. (For more 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 is not on the Drug List. (For more information, go to Chapter 7.)

Please note: These prescription drugs may be covered by the additional coverage provided by NYSHIP. Please contact Empire Plan Medicare Rx.

Section 3.2 Three cost-sharing tiers for drugs on the Formulary

Every drug on our Plan's Formulary is in one of three cost-sharing tiers. In general, the higher the tier, the higher your cost is for the drug:

- **Cost-Sharing Tier 1: Generic** – includes most generic drugs and some lower-cost brand-name prescription drugs. Tier 1 is the lowest cost-sharing tier, at $5 for up to a 30-day supply and $10 for up to a 90-day supply at retail ($5 at mail).
- **Cost-Sharing Tier 2: Preferred Brand** – includes many common brand-name drugs. Tier 2 copays are $30 for up to a 30-day supply and $60 for up to a 90-day supply at retail ($55 at mail).
- **Cost-Sharing Tier 3: Non-Preferred Brand** – includes non-preferred brand-name drugs. Tier 3 is typically where you will see the highest cost-sharing amount, at $60 for up to a 30-day supply and $120 for up to a 90-day supply at retail ($110 at mail).

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

Please note: NYSHIP provides supplemental coverage that may differ in structure from the primary benefit and also cover additional medications. There may be instances where your cost share may be less when it is paid by the supplemental coverage. If you are unsure about the cost share on the supplemental coverage, or which drugs may or may not be covered, please call Empire Plan Medicare Rx at The Empire Plan phone number to verify prescription drug coverage.

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

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

1. Check the most recent Formulary we sent you in the mail. (The Formulary includes information for the covered drugs most commonly used by our members. We cover additional drugs that are not included in the Formulary. If one of your drugs is not listed visit our Plan's website at empireplanrxprogram.com or call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) to find out if we cover it.)
2. Visit our Plan's website at empireplanrxprogram.com. The Formulary on the website is always the most current.

3. Call Empire Plan Medicare Rx at The Empire Plan phone number to find out if a particular drug is on our Plan's Formulary or ask for a copy of the list.
4. Use our plan's Real-Time Benefit Tool (empireplanrxprogram.com) to search for drugs on the Drug List to get an estimate of what you will pay and see if there are alternative drugs on the Drug List that could treat the same condition.

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 on our Formulary. 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

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

If there is a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Empire Plan Medicare Rx at 1-877-769-7447. (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 do not get this approval, your drug might not be covered by our Plan. Our plan's prior authorization criteria can be obtained by calling Empire Plan Medicare Rx 1-877-769-7447. (TTY users call 711).

Quantity limits

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

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

There are situations in which a prescription drug you take, or that you and your provider think you should take, is not on our Formulary 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 is not 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 copayment 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.**

NYSHIP provides supplemental coverage that may cover additional medications in addition to your primary Medicare Part D benefit. This coverage is sometimes referred to as a secondary "Wrap" plan that enhances your coverage to be better than the standard Medicare benefit. As such, your drug may be covered. For more information on your coverage for a particular drug, please contact Empire Plan Medicare Rx. (Phone numbers are printed on the back cover of this document.)

If your drug is not on the Formulary, or is restricted, here are options for what you 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 are already taking. This temporary supply gives you time to talk with your provider about the change.

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

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in our Plan.
- **If you were in our Plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. If you use an out-of-network pharmacy, a paper claim must be submitted for reimbursement (amount is dependent upon a review of the claim).

(Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who have been in our Plan for more than 90 days and live in a long-term care facility and need a supply right away:**

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

- If you experience a change in your level of care, such as a move from a long-term care to a home setting, and you need a drug that is not on our formulary (or if your ability to get your drugs is limited), we may cover a one-time temporary supply from a network pharmacy for up to 31 days unless you have a prescription for fewer days. You should use our Plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For questions about a temporary supply, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).

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

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our Plan might work just as well for you. Call Empire Plan Medicare Rx at 1-877-769-7447. (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 would 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 Formulary. Or, you can ask our Plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you take will be removed from the Formulary or restricted in some way for next year, we will tell you about any change

before the new year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we will 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 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 Empire Plan Medicare Rx at 1-877-769-7447. (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 for you and cover the prescription drug in the way you would like it to be covered. 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.

SECTION 6 Our Drug List can change during the year

NYSHIP is providing coverage that is supplemental to your Medicare Part D prescription drug coverage. The secondary coverage is sometimes referred to as a "Wrap" plan that may cover more than your primary Medicare Part D coverage. For more information on your coverage for a particular drug, please contact Empire Plan Medicare Rx at The Empire Plan phone number. (Phone numbers are printed on the back cover of this document.)

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 Formulary. For example, our Plan might:

- **Add or remove drugs from the Formulary.**
- **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 Formulary.

Information on changes to drug coverage

When changes to the Formulary occur, we post information on our website about those changes. We also update our online Formulary regularly. Sometimes you will get direct notice if changes are made to a drug you take. You can also call Empire Plan Medicare Rx for more information.

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 Formulary.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug on our Formulary, 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 with the same or fewer restrictions.
    - We will make these immediate changes only if we are 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 will 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 will 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 will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.

- **Removing unsafe drugs and other drugs on the Formulary 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 Formulary. If you take that drug, we will tell you after we make the change.

- **Making other changes to drugs on the Formulary.**
    - We may make other changes once the year has started that affect drugs you take. For example, we might add a generic drug that is not new to the market to replace a brand-name drug on the “Drug List” or change the cost-sharing tier or add new restrictions to the brand-name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking at a network pharmacy.

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 are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking.

For more information on how to ask for a coverage decision, including an exception, go to Chapter 7.

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

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

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

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

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 previous sections), then the change will not affect your use or what you pay as your share of the cost until January 1 of the next year.

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

SECTION 7 Types of drugs we do not cover

Some kinds of prescription drugs are *excluded*. This means Medicare does not pay for these drugs.

Please note: NYSHIP has elected to cover some of the drugs listed below as a supplemental benefit. This coverage is sometimes referred to as the secondary "Wrap" benefit, which includes coverage for certain drugs not covered by Medicare Part D. Please contact Empire Plan Medicare Rx at The Empire Plan phone number (phone numbers are printed on the back cover of this document) if you have questions about your supplemental drug coverage. The additional Empire Plan Medicare Rx benefits include coverage for Medicare Part B prescription drugs dispensed by a network pharmacy and covered drugs purchased outside the United States and its territories. Also, certain drugs that are covered by Medicare are

excluded from coverage under Empire Plan Medicare Rx in accordance with The Empire Plan benefit design.

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

Here are 3 general rules about drugs that Medicare drug plans will not cover under Part D:

- Our Plan's Part D prescription drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our Plan cannot cover a drug purchased outside the United States or its territories.
- Our Plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label use* is any use of the drug other than those indicated on a drug's label as approved by the FDA.
- In addition, by law, the following categories of drugs are not covered by Medicare Prescription Drug Plans:
    - Non-prescription drugs (also called over-the-counter drugs)
    - Drugs used to promote fertility
    - Drugs used for the relief of cough or cold symptoms
    - Drugs used for cosmetic purposes or to promote hair growth
    - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
    - Drugs used for the treatment of sexual or erectile dysfunction
    - Drugs used for treatment of anorexia, weight loss, or weight gain
    - Outpatient drugs for which the manufacturer 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 learn which drugs are excluded from the enhanced coverage, please contact Empire Plan Medicare Rx at The Empire Plan phone number (phone numbers are printed on the back cover of this document). The amount you pay for these drugs does not count toward

qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 6.)

If you get **Extra Help from Medicare** to pay for your prescriptions, Extra Help will not pay for drugs that are not normally covered. 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 prescription drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in the Appendix.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our Empire Plan Medicare Rx membership information, (which can be found on your membership card) at the network pharmacy you choose. While your Plan includes primary and supplemental coverage, you will have one Medicare Rx membership card. 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 do not have our Plan membership information with you, you or the pharmacy can call Empire Plan Medicare Rx to get the information, or you can ask the pharmacy to look up our Plan enrollment information.

If the pharmacy cannot 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 are **admitted to a hospital** or to a skilled nursing facility the, 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 are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it is not, or if you need more information or help, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) . If you are in an LTC facility, we must ensure that you are able to routinely get your Part D benefits through our network of LTC pharmacies.

If **you are a resident in** an **LTC** facility and need a drug **that is 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 Empire Plan Medicare Rx does not affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in our Plan If your drug would be covered by Medicare Part A or Part B, our Plan cannot cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through Empire Plan Medicare Rx 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 Medicare Part B or Empire Plan Medicare Rx for the drug.

Section 9.4 If you have a Medigap (Medicare Supplement Insurance) policy with drug coverage

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

Each year, your Medigap insurance company should send you a notice that tells if your prescription drug coverage is creditable, and the choices you have for prescription drug coverage. (If the coverage from the Medigap policy is creditable, it

means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you did not get this notice, or if you cannot find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 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 benefits administrator.** They can help you understand how your current drug coverage will work with Empire Plan Medicare Rx.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. Also, if you have prescription drug coverage as the result of your spouse's active employment, in general, Empire Plan Medicare Rx will be secondary. That means your active employer group coverage pays first before Medicare.

Special note about Creditable Coverage:

If you currently have other prescription drug coverage other than Empire Plan Medicare Rx, that group's benefits administrator 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 our 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 did not get a Creditable Coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 If you are in a Medicare-certified hospice

Hospice and our Plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our Plan must 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 are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

Section 10.1 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.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are 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 to members. A team of pharmacists and doctors developed the program for us. The program can 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 will 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 will also get a medication list that will include all the medications you are 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 is 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 any time 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 will automatically enroll you in the program and send you information. If you decide not to participate, notify us and will withdraw you. For questions about this program, call Empire Plan Medicare Rx at 1-877-769-7447. (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 have included a separate insert called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your prescription drug coverage. If you do not have this insert, call Empire Plan Medicare Rx at 1-877-769-7447. (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. NYSHIP also provides supplemental coverage that may cover additional medications in addition to your primary Medicare Part D benefit. This coverage is sometimes referred to as a secondary "Wrap" plan that enhances your coverage to be better than the standard Medicare benefit. Please refer back to Chapter 3 to find more information about the type of coverage you have with NYSHIP.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules 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 (empireplanrxprogram.com), the cost you see shows an estimate of the out-of-pocket costs you are expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Empire Plan Medicare Rx at 1-877-769-7447. (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:

- **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 does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <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 are 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, by a State Pharmaceutical Assistance Programs (SPAPs), and most charities.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

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

- Your monthly premium
- Drugs you buy outside the United States and its territories.

- Drugs that are not covered by our Plan
- Drugs you get at an out-of-network pharmacy that do not meet our Plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare 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 are required to tell our Plan by calling Empire Plan Medicare Rx at 1-877-769-7447. (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 $2,100, 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 Empire Plan Medicare member

There are **3 drug payment stages** for your drug coverage under Empire Plan Medicare Rx. How much you pay for each prescription depends on what stage you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the Plan's monthly premium 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

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our Plan, no matter what cost-sharing tier it is on.

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

Our Plan keeps track of your prescription drug cost, 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 filled through our Plan during the previous month, we will send you a *Part D EOB*. You have the option to receive your *Part D EOB* electronically. It provides the same information as in the paper *EOB* you received in the mail today. To opt in to receive paperless *EOBs*, visit Caremark.com/startnow to register. You will receive email notification when you

have a new *EOB* to view. You can opt out at any time by contacting Empire Plan Medicare Rx at The Empire Plan phone number. Be sure to keep these summaries.

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, 2026.** 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 is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay. You will have one membership card for your primary Medicare and secondary "Wrap" coverage.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **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 is 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 are billed for a covered drug, you can ask our Plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5.

- **Send us information about the payments others 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 summary 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 Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).

SECTION 4 The Deductible Stage

There is no deductible for Empire Plan Medicare Rx. 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 copayment. Your share of the cost will vary depending on the drug and where you fill your prescription.

Our Plan has three cost-sharing tiers

Every drug on our Plan's Formulary is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost (copayment) for the drug.

- **Cost-Sharing Tier 1: Generic –** includes most generic drugs and some lower-cost brand-name drugs. Tier 1 is the lowest cost-sharing tier, at $5 for up to a 30-day supply and $10 for up to a 90-day supply at retail ($5 at mail).

- **Cost-Sharing Tier 2: Preferred Brand –** includes many common brand-name drugs. Tier 2 copays are $30 for up to a 30-day supply and $60 for up to a 90-day supply ($55 at mail).
- **Cost-Sharing Tier 3: Non-Preferred Brand –** includes non-preferred brand-name drugs. Tier 3 is typically where you will see the highest cost-sharing amount, at $60 for up to a 30-day supply and $120 for up to a 90-day supply ($110 at mail).

You won't pay more than $35 for a one-month supply $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

To find out which cost-sharing tier your drug is in, please refer to our *Empire Plan Medicare Rx Comprehensive Formulary*. You may also reference your "Benefits at a Glance" materials for more information.

Your pharmacy choices

How much you pay for a drug may vary depending on whether you get the drug from:

- A network retail pharmacy.
- A pharmacy that is not in our Plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 3, Section 2.4 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- Our Plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 3 and our Plan's *Pharmacy Directory*.

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 either a copayment or coinsurance.

The amount you pay depends on which 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 cost for a *one-month* supply of a covered Part D drug:

Tier	Standard Retail Cost-Sharing (In Network) (Up to a *30*-day supply)	Long-Term Care (LTC) Cost-Sharing (Up to a *31*-day supply)	Mail-Order Cost-Sharing (Up to a *30*-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	*$5.00*	*$5.00*	*$5.00*	*$5.00*
Cost-Sharing Tier 2: Preferred Brand	*$30.00*	*$30.00*	*$30.00*	*$30.00*
Cost-Sharing Tier 3: Non-Preferred Brand	*$60.00*	*$60.00*	*$60.00*	*$60.00*

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 are trying a medication for the first time). You can ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

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

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

*Prorated cost share does not apply to non-Medicare Part D drugs. Proration only applies to copays (not dispensing fees), and only applies to oral, solid maintenance medications (excludes antibiotics, unbreakable packages, and compounds).

Section 5.4 Your costs for a *long-term* (up 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) when you fill your prescription. 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. If your drug is covered, you will not be responsible for amounts higher than the applicable cost-sharing tier copay.

Your cost 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)	Mail-Order Cost-Sharing (Up to a 90-day supply)
Cost-Sharing Tier 1: Generic	*$10.00*	*$5.00*
Cost-Sharing Tier 2: Preferred Brand	*$60.00*	*$55.00*
Cost-Sharing Tier 3: Non-Preferred Brand	*$120.00*	*$110.00*

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

Section 5.5 You stay in the Initial Coverage Stage until your total drug out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move on to the Catastrophic Coverage Stage.

NYSHIP offers supplemental coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. This coverage is sometimes referred to as a secondary "Wrap" plan that enhances your coverage to be better than the standard Medicare benefit. Payments made for these drugs will not 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 for your drugs during the year. You will receive your EOB each month that you fill medications. Not all members will reach the $2,100 out-of-pocket limit in a year.

We will 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 once your true out-of-pocket costs reach $2,100 for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.
- For excluded drugs covered under our enhanced benefit, you pay the same cost share as you did in the Initial Coverage Period.

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 Part D vaccines at no cost to you. Refer to our plan's Drug List

or call the Empire Plan Medicare Rx at 1-877-769-7447. (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 a provider **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 are 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 will 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.
- The Empire Plan covers certain preventive vaccines based on recommendations from the U.S. Preventive Services Task Force (USPSTF) and in accordance with the Patient Protection and Affordable Care Act (PPACA) mandates with a zero-dollar copay.

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 do not allow pharmacies to administer certain vaccines.)

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

Situation 2: You get the Part D 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. (Empire Plan Medical/Surgical Program benefits apply if you use a participating provider and, in some cases, Basic Medical Program benefits may be available for certain vaccines administered by a non-participating provider. Contact The Empire Plan Medical/Surgical Program for details.)
- If you pay the full cost and do not use your Empire Plan Medical/Surgical Program benefits, you can then ask our Plan to pay our share of the cost by using the procedures that are described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration) and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at 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 the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service. Empire Plan Medical/Surgical Program benefits apply if you use a participating provider and, in some cases, Basic Medical

Program benefits may be available for certain vaccines administered by a non-participating provider.

- Contact the Empire Plan Medical/Surgical Program for details. You can then ask our Plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine administration and less any difference between the amount the doctor charges and what we normally pay. (If you get “Extra Help,” we will reimburse you for this difference.)

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 have 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 backpay 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 and submit a paper claim to be reimbursed.

   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 2.4 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 would pay at an in-network pharmacy.

2. **When you pay the full cost for a prescription because you do not have our Plan membership card with you**

   If you do not 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 cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

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

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

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

- For example, the drug may not be on our Plan's Drug List or it could have a requirement or restriction you did not know about or do not 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 are 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 will need to submit paperwork for us to handle the reimbursement.

- Ensure you provide this information no later than three (3) years from the date of service. Claims submitted after that date may not be processed. If you need to request an appeal on your denied paper claim, you must submit that request (with the **Empire Plan Medicare Rx Prescription Reimbursement Claim Form**) within 60 days from the date of the notice of the coverage determination (i.e., the date printed or written on the notice).

When you send us a request for payment, we'll review your request and decide whether the service or 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 service or 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 is a good idea to make a copy of your receipts for your records.

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

- You do not have to use the form, but it will help us process the information faster.
- Download a copy of the form from our website (empireplanrxprogram.com) or call Empire Plan Medicare Rx at 1-877-769-7447. (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:

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

SECTION 3 We will consider your request for payment and make a coverage decision

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

- If we decide the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you 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 will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.
- If we decide the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the

reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.1 If we tell you that Empire Plan Medicare Rx will not 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 are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7. The examples of situations in which you may need to ask our Plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you do not have your Plan membership card with you
- When you pay the full cost for a prescription in other situations

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 are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our Plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about our Plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, call Empire Plan Medicare Rx Customer Care 1-877-769-7447. (TTY users call 711).

If you have any trouble getting information from our Plan in a format that is accessible and appropriate for you, call to file a grievance with SilverScript Insurance Company, Grievance Department, P.O. Box 14834, Lexington, KY 40512-4834. Fax: 1-724-741-7956. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) 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 are not getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

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

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

If you have questions or concerns about the privacy of your protected health information, call Empire Plan Medicare Rx at The Empire Plan at 1-877-769-7447. (TTY users call 711).

Section 1.4 We must give you information about the Plan, its network of pharmacies, and your covered drugs

As a member of Empire Plan Medicare Rx, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Empire Plan Medicare Rx at The Empire Plan at 1-877-769-7447. (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 from us about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and rules you must follow in 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 on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 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 is 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 are 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 at some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter of where you get this form, it is 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 cannot. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you did not 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 are in the hospital). According to law, no one can deny you care or

discriminate against you based on whether or not you have signed an advance directive.

If your instructions are not followed

If you sign an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state licensing board. Your State Department of Health may be able to help you find the appropriate agency. Please see the Appendix at the end of this document to find the contact information for your State Department of Health.

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

If you have any problems, concerns, 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 are required to treat you fairly.**

Section 1.7 If you believe you are being treated unfairly or your rights are not being respected

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

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

- **Call Empire Plan Medicare Rx at The Empire Plan at 1-877-769-7447. (TTY users call 711).**
- **Call your local SHIP** For details, go to Chapter 2, Section 3.
- 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 Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).**
- **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 Empire Plan Medicare Rx at 1-877-769-7447. (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 is 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 are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our Plan.** Show 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 that you and your doctors agree on.
    - Make sure your doctors know all the drugs you are 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 are responsible for these payments:
    - You, or NYSHIP, must pay our 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 are required to pay a Part D 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 federal 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* of our Plan service area, you cannot stay a member of our Plan.**

- **If you move and you are a New York State (NY) or Participating Employer (PE) retiree, you must notify the New York State Department of Civil Service Employee Benefits Division by telephone or by submitting a change of address form (Form PS-850). The Employee Benefits Division may be reached at 1-518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands), Monday through Friday between 9 a.m. and 4 p.m. (Eastern time). The PS-850 can be found under "Forms" at www.cs.ny.gov/employee-benefits.**

- **If you move and you are a Participating Agency (PA) retiree, you must notify your Health Benefits Administrator by telephone or in writing of your new address.**

- **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 is 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 are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. You should always reach out to Empire Plan Medicare Rx Customer Care at 1-877-769-7447. (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who is not 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 are 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 the Appendix 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 should 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 deals 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 services

If you want to know if we will cover medical 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 will 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 will 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 are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected with 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 Empire Plan Medicare Rx at 1-877-769-7447. (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 other person to be your representative, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) 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 cannot begin or complete our review until we get it. If we do not get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you

qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 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 do not 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 will cover it.

- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

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

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

- Asking to cover a Part D drug that is not on 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 is 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 is not covered in the way you would like it to be covered, you can ask us to make an exception. An exception is a type of coverage decision.

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

1. **Covering a Part D drug that is not on our Drug List.** If we agree to cover a drug not on the "Drug List," you will need to pay the cost-sharing amount that applies to drugs in Tier 3. It is possible that your supplemental plan will cover a portion of

your drug cost as well. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

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

   - If our Formulary contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you are taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier cost that contains biological product alternatives for treating your condition.
   - If the drug you are taking is a brand-name drug you can ask us to cover your drug at the amount that applies to the lowest cost-sharing tier that contains brand-name alternatives for treating your condition.
   - If the drug you are taking is a generic drug you can ask us to cover your drug at the amount that applies to the lowest cost-sharing tier that contains either brand or generic alternatives for treating your condition.
   - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you cannot 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 are 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 Formulary includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we generally will *not* approve your request for an exception. If you ask us for a cost-sharing tiering exception, we generally will *not* approve your

request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) will not 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 doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

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

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

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We will 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*. 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 are 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 will give you our answer within 24 hours after we get your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

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

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

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

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

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

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

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going 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 prescription 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 are 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 the contact information.
- **For fast appeals, either submit your appeal in writing or call us at the phone number shown in Chapter 2.**
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website empireplanrxprogram.com. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we send 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 causes 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. We are allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you 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 will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you did not get yet

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

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

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

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

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

Section 5.6 How to make a Level 2 appeal

Legal Term:

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

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

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

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the 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 will 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**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all 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 did not get yet. If 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 prescription drug coverage** that was approved by the independent review organization **within 72 hours** after we receive 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 are 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 is also called *turning down your appeal*.) In this case, the independent review organization will send you a letter:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you are asking for meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- 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 cannot appeal any further. The written response you receive 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 Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's 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 do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, 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 dissatisfied with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you dissatisfied with Empire Plan Medicare Rx? • Do you feel you are being encouraged to leave our Plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by Empire Plan Medicare Rx or other staff at our Plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you dissatisfied 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 are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms:

- A **complaint** is also called a **grievance.**
- **Making a complaint** is 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 Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) is usually the first step.** If there is anything else you need to do, Empire Plan Medicare Rx will let you know.
- **If you do not want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **You may submit a grievance via fax at 1-724-741-4956. Or, you may send it to us in writing to:**

  SilverScript Insurance Company
  Prescription Drug Plans
  Grievance Department
  P.O. Box 14834
  Lexington, KY 40512-4834

  Upon receipt of your complaint, we will initiate the grievance process.

  - We will respond to you in writing if you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care.
  - We must notify you of our decision about your complaint (grievance) as quickly as your situation requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

- **In certain cases, you have the right to ask for a fast review of your complaint.** This is called the Expedited Grievance Process. You are entitled to a fast review of your complaint in the following situations:
    - We deny your request for a fast review of a request for drug benefits.
    - We deny your request for a fast review of an appeal of denied drug benefits.
- You may request an expedited grievance by calling Empire Plan Medicare Rx at The Empire Plan phone number on the previous page. We will contact you within 24 hours by phone to notify you of our response. This will also be followed up by a written response.
- The complaint must be submitted within 60 days of the event or incident. The address for filing complaints is located in Chapter 2 under **How to contact us when you are making a complaint about your Part D prescription drugs.** We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it and will tell you about any dispute resolution options you may have.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (total of 44 calendar days) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a *fast coverage decision* or a *fast appeal*, we will automatically give you a *fast complaint*.** If you have a *fast complaint*, it means we will give you **an answer within 24 hours**.

- **If we do not agree** with some or all of your complaint or do not take responsibility for the problem you are complaining about, we will 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 Empire Plan Medicare Rx 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 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 Empire Plan Medicare Rx 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 are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

SECTION 2 When can you end your membership in our Plan

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

IMPORTANT, please note: The Empire Plan requires its Medicare-primary members be enrolled in Empire Plan Medicare Rx to remain enrolled in hospital, medical/surgical, and mental health and substance use benefits through The Empire Plan. Therefore, cancellation of your Empire Plan Medicare Rx prescription drug coverage will also cancel all of your Empire Plan benefits including hospital, medical/surgical, and mental health and substance use coverage. If you are the enrollee and have family coverage, Empire Plan benefits for you and all of your covered dependents will be terminated. If you are covered as a dependent, only your Empire Plan benefits will be terminated. The cancellation effective date of your Empire Plan benefits will be communicated to you in a letter sent by the New York State Department of Civil Service.

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.

- **The Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare Drug Plan
    - Original Medicare *with* a separate Medicare Drug
    - Original Medicare *without* a separate Medicare Drug Plan
        - If you choose this option and receive Extra Help, Medicare may enroll you in a Prescription Drug Plan, unless you have opted out of automatic enrollment.
    - A Medicare Health Plan. A Medicare Health Plan is a plan offered by a private company that contracts with Medicare to provide all the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Health Plans also include Part D prescription drug coverage.
        - If you enroll in most Medicare Health Plans, you will be automatically disenrolled from Empire Plan Medicare Rx when your new Plan's coverage begins. If you do not want to keep our Plan, you can choose to enroll in another Medicare Prescription Drug Plan or drop Medicare prescription drug coverage.

Note: If you disenroll from Medicare prescription drug coverage and go without Creditable Prescription Drug Coverage for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare Prescription Drug Plan later.

- **Your membership will end in our Plan** when your new Plan's coverage begins on January 1.

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

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

IMPORTANT, please note: Cancellation of your Empire Plan Medicare Rx prescription drug coverage will also cancel all of your Empire Plan benefits including hospital, medical/surgical, and mental health and substance use coverage.

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 (see Section 2.3 for contact information), call Medicare, or visit the Medicare website Medicare.gov:

- Usually, when you move
- If you have Medicaid
- If you are eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711)
- **Note**: If you are 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 are 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 are 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 will automatically be disenrolled from Empire Plan Medicare Rx 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 Empire Plan Medicare Rx for your drug coverage. If you do not want to keep our Plan, you can choose to enroll in another Medicare drug plan or to drop Medicare prescription 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 our 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 the New York State Department of Civil Service–Employee Benefits Division at 1-518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands), Monday through Friday between 9 a.m. and 4 p.m. (ET)
- Visit the New York State Department of Civil Service–Employee Benefits Division website at www.cs.ny.gov/employee-benefits/login/index-retiree.cfm
- Refer to your NYSHIP Plan materials
- Call Empire Plan Medicare Rx at The Empire Plan **at 1-877-769-7447. (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** 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 following table explains how you can end your membership in our Plan:

To switch from our Plan to:	Here is what to do:
• **Another Medicare health plan**	Enroll in the new Medicare Prescription Drug Plan between October 15 and December 7. You will automatically be disenrolled from Empire Plan Medicare Rx when your new Plan's coverage begins.
• **Original Medicare *with* a separate Medicare drug plan**	• Enroll in the new Medicare drug Plan • You will automatically be disenrolled from Empire Plan Medicare Rx when your new drug Plan's coverage starts
• **Original Medicare *without* a separate Medicare drug plan**	• **Send us a written request to disenroll.** Call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711) if you need more information on how to do this. • 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 will be disenrolled from Empire Plan Medicare Rx 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 to get your prescriptions filled.** If you use an out-of-network pharmacy, we will reimburse you your total cost minus your cost-share amount for the drug. You must submit a paper claim in order to be reimbursed. (See Chapter 3 Section 2 for more information.)

SECTION 5 Empire Plan Medicare Rx must end your membership in certain situations

Empire Plan Medicare Rx must end your membership in our Plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
    - In addition to paying the monthly Plan premium, you must continue paying your Medicare premiums to stay a member of our Plan. This includes any Medicare Part D IRMAA you may owe (see section 4.4 for information on IRMAA).
- If you move outside the United State or its territories.
- If you are outside the United States or its territories for more than 12 months.
    - If you move or take a long trip, call the New York State Department of Civil Service–Employee Benefits Division at 1-518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands), Monday through Friday between 9 a.m. and 4 p.m. (ET) to find out if the place you are moving or traveling to is in our Plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan. (We cannot make you leave our Plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our Plan. (We cannot make you leave our Plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our Plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you are not receiving Extra Help and you, or your employer, do not pay our Plan premiums by the due date.
    - We must notify you, or your employer, in writing that you have 60 days from the due date to pay our Plan premium before we end your membership.
- If you are required to pay the extra Part D amount (Part D Income-Related Monthly Adjustment Amount or Part D IRMAA) because of your income and you do not pay it, Medicare will disenroll you from our Plan, and you will lose drug coverage.

If you have questions or want more information on when we can end your membership, call Empire Plan Medicare Rx at 1-877-769-7447. (TTY users call 711).

Section 5.1 We cannot ask you to leave our Plan for any health-related reason

Empire Plan Medicare Rx is not allowed to ask you to leave our Plan for any health-related reason.

What should you do if this happens?
If you feel that you are being asked to leave our Plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). 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 are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We do not 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, and all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, 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, please call Empire Plan Medicare Rx at The Empire Plan phone number. If you have a complaint, such as a problem with wheelchair access, The Empire Plan 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, Empire Plan Medicare Rx, as a Medicare

Prescription Drug Plan sponsor, will exercise the same rights of recovery that the secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR, and the rules established in this section supersede any state laws.

SECTION 4 Other important legal notices

Prescription drug names listed in this and any other Plan documents are the registered and/or unregistered trademarks of third-party pharmaceutical companies unrelated to and unaffiliated with SilverScript Insurance Company or its affiliates. We include these trademarks here for informational purposes only and do not imply or suggest affiliation between the Plan sponsor and such third-party pharmaceutical companies.

SECTION 5 Member liability

In the event we fail to reimburse a network pharmacy's charges for covered drugs, or in the event that we fail to pay a non-network pharmacy for prior authorized covered drugs occurring when you were actively enrolled in the Plan, you will not be liable for any sums owed by us.

We will pay for certain drugs dispensed by a non-network pharmacy under certain circumstances, subject to the limitations contained in Chapter 3.

If you enter into a private contract with a non-network provider, neither the Plan nor Medicare will pay for those services except as required by and in accordance with our policy on out-of-network claims.

SECTION 6 Nonduplication of benefits with automobile, accident, or liability coverage

If you are receiving benefits as a result of other automobile, accident, or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident, or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under state and/or federal law. We will provide benefits over and above your other automobile, accident, or liability coverage if the cost of your drugs exceeds such coverage and

are covered by our Plan. You are required to cooperate with us in obtaining payment from your automobile, accident, or liability coverage carrier.

SECTION 7 Acts beyond your control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network pharmacies may become unavailable to arrange or provide health services pursuant to this 2026 *Evidence of Coverage* and disclosure information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network pharmacy shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

SECTION 8 Contracting network pharmacies

The relationship between us and our network pharmacy providers are independent contractor relationships. None of the network pharmacy providers, or their pharmacists or employees, are employees of SilverScript Insurance Company. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of SilverScript Insurance Company is an employee of the network pharmacy.

SECTION 9 Disclosure

This Plan is insured or provided by SilverScript Insurance Company, a Medicare-approved Part D Prescription Drug Plan sponsor.

SECTION 10 Information upon request

As a Plan member, you have the right to request information on the following:

- General coverage information
- Certain quality and performance indicators
- Statistical data on grievances and appeals
- Financial condition of SilverScript Insurance Company

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.

Basic Medical Program – The Empire Plan includes basic medical coverage to provide benefits when enrollees use non-participating providers. These benefits will be paid directly to enrollees according to usual and customary charges and will be subject to combined annual deductible, coinsurance, and calendar year and lifetime maximums.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (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 $2,100 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 pay nothing for your covered Part D drugs and 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 does not follow the time periods in the appeal process.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount (for example $10), rather than a percentage. The amount is based on the cost-sharing tier of the medication you are taking, the days' supply you are taking and where you are filling your prescription.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are gotten. Cost sharing includes (1) any fixed *copayment* amount that a plan requires when a specific drug is gotten; or (2) 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 three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost will be 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 are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered under our Plan, that is not 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 Care – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 or the back cover of this document for information about how to contact Empire Plan Medicare Rx.

Daily Cost-Sharing Rate – A *daily cost-sharing rate* may apply when your doctor prescribes less than a full month's supply of certain drugs for you, and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30.00, and a one-month's supply in our Plan is 30 days, then your *daily cost-sharing rate* is $1.00 per day.

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 are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Empire Plan Medicare Rx – An Employer Prescription Drug Plan (PDP) that is offered by SilverScript Insurance Company, which has a Medicare contract. See Chapter 2 or the back cover of this document for information about how to contact Empire Plan Medicare Rx.

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 must 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 the lower cost-sharing tier (a cost-sharing tiering exception). You may also ask for an exception if our Plan requires you to try another drug before getting the drug you are 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 are 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.

Formulary – A list of prescription drugs covered by the Plan. The drugs on this list are selected by the Plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Generic Drug – A prescription drug that is 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 does not involve coverage or payment disputes.

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

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

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you are eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65. There is an exception: If your birthday falls on the first of any month, your 7-month IEP begins and ends one month sooner. For example, if your birthday is July 1, your 7-month IEP is the same as if you were born in June — beginning in March and ending in September. Please note that NYSHIP requires that you be enrolled in Medicare as soon as you are entitled to Medicare coverage that is primary to NYSHIP.

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) – 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 an i) an HMO, ii) a PPO, iii) Private Fee-for-Service (PFFS) Plan, or a iv) Medicare Medical Savings Account (MSA) Plan. Besides choosing from these types of Plans, a Medicare Advantage HMO or PPO Plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These Plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

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

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

Medicare Health Plan – A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in 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 CMS.

Network Pharmacy – A pharmacy that contracts with our Plan where members of our Plan can get their prescription drug benefits and charge members their appropriate cost sharing.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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 is 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 does not have a contract with our Plan to coordinate or provide covered drugs to members of our Plan.

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 them stay independent and living in their community (instead of moving to a nursing home) for 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, please contact Empire Plan Medicare Rx at The Empire Plan at 1-877-769-7447. (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 prescription drug coverage if you go without Creditable Coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

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

Prior Authorization – Approval in advance to get certain drugs 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 – An online drug pricing tool within your secure member portal at empireplanrxprogram.com in which enrollees can look up specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, 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. Under NYSHIP, you may be able to change your health plan in accordance with NYSHIP rules. Contact NYSHIP or refer to your *NYSHIP General Information Book* for additional information.

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

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

Appendix A – Important Contact Information for State Agencies

	Quality Improvement Organizations (QIO)
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-319-8452, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 2: New Jersey, New York, Puerto Rico, Virgin Islands	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **Phone:** 1-866-815-5440, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **Phone:** 1-888-396-4646, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0751, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **Phone:** 1-888-524-9900, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-315-0636, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 7: Iowa, Kansas, Missouri, Nebraska	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **Phone:** 1-888-755-5580, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0891, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com
Region 9: Arizona, California, Hawaii, Nevada, Northern Mariana Islands	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **Phone:** 1-877-588-1123, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, **Website:** livantaqio.cms.gov/en

	Quality Improvement Organizations (QIO)
Region 10: Alaska, Idaho, Oregon, Washington	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-305-6759, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com

	State Medicaid Office
Alabama	**Alabama Medicaid Agency**, **Address:** Central Office, 501 Dexter Avenue, Montgomery, Alabama 36104, **Phone:** 1-800-362-1504, 334-242-5000, **TTY:** 1-800-253-0799 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** medicaid.alabama.gov/
Alaska	**Alaska Medicaid**, **Address:** Alaska Department of Health, Division of Public Assistance, PO Box 110640, 350 Main Street, Room 304, Juneau, AK 99811-0640, **Phone:** 1-800-780-9972 (coverage or billing), 1-800-478-7778 (eligibility), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx
American Samoa	**American Samoa Medicaid State Agency**, **Address:** PO Box 998383, Pago Pago, AS 96799, **Phone:** 684-699-4777 684-699-4778, **TTY:** 711, **Hours:** Monday-Friday 8:00 AM-5:00 PM, **Website:** medicaid.as.gov
Arizona	**Arizona Health Care Cost Containment System (AHCCCS)**, **Address:** Office of Individual and Family Affairs (OIFA), 801 E. Jefferson Street, Phoenix, AZ 85034, **Phone:** 1-800-654-8713, 602-417-4000, **TTY:** 1-800-842-6520 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 9:00 PM, Saturday 8:00 AM to 6:00 PM, **Website:** azahcccs.gov/
Arkansas	**Arkansas Medicaid**, **Address:** Arkansas Department of Human Services, PO Box 1437, Slot S401, Little Rock, AR 72203-1437, **Phone:** 1-855-372-1084, 1-800-482-5431, **TTY:** 501-682-8933 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 7:00 PM, **Website:** humanservices.arkansas.gov/divisions-shared-services/medical-services/
California	**Medi-Cal (California's Medicaid program)**, **Address:** California Department of Health Care Services, 1501 Capitol Avenue, Sacramento, CA 95814, **Phone:** 1-800-541-5555, 916-552-9200, **TTY:** 1-800-430-7077 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhcs.ca.gov/services/medi-cal/Pages/default.aspx
Colorado	**Health First Colorado**, **Address:** Colorado Department of Health Care, Policy & Financing, 303 E. 17th Avenue, Denver, CO 80203, **Phone:** 1-800-221-3943, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, third Thursday of each month 8:00 AM to 2:00 PM, **Website:** healthfirstcolorado.com/

	State Medicaid Office
Connecticut	**HUSKY Health (Connecticut's Medicaid program)**, **Address:** HUSKY Health Program, c/o Department of Social Services, 55 Farmington Ave., Hartford, CT 06105-3724, **Phone:** General Information: **1-877-284-8759**, Member Services **1-800-859-9889**, **TTY:** **1-866-492-5276** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** General Information: Monday–Friday 7:30 AM to 4:00 PM, Member Services: Monday–Friday 8:00 AM to 6:00 PM, **Website:** **portal.ct.gov/HUSKY/Welcome**
Delaware	**Delaware Medicaid**, **Address:** Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA), 1901 N. DuPont Highway, New Castle, DE 19720, **Phone:** **1-866-843-7212**, **302-571-4900**, **TTY:** **1-855-889-4325** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** **dhss.delaware.gov/dhss/dmma/medicaid.html**
District of Columbia	**DC Medicaid**, **Address:** The Department of Health Care Finance – DHCF, 441 4th Street NW, 900S, Washington, DC 20001, **Phone:** **202-442-5988**, **TTY:** **711**, **Hours:** Monday–Friday 8:15 AM to 4:45 PM, **Website:** **dhcf.dc.gov/service/medicaid**
Florida	**Florida Division of Medicaid**, **Address:** Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308, **Phone:** **1-877-711-3662**, **850-412-4000**, **TTY:** **1-866-467-4970** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Thursday, 8:00 AM to 8:00 PM, Friday 8:00 AM to 7:00 PM, **Website:** **ahca.myflorida.com/medicaid**
Georgia	**Georgia Medicaid**, **Address:** The Department of Community Health (DCH), 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334, **Phone:** Toll Free: **1-877-423-4746**, Customer Service: **404-657-5468**, Eligibility: **404-651-9982**, Member Services: **866-211-0950**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **medicaid.georgia.gov/**
Guam	**Guam Medicaid**, **Address:** Department of Public Health & Social Services, 761 South Marine Corps Drive, Tamuning, GU 96913, **Phone:** **671-300-7330**, **TTY:** **711**, **Hours:** 8:00 AM to 4:00 PM, **Website:** **dphss.guam.gov**
Hawaii	**Hawaii Med-QUEST (Quality, Universal Access, Efficiency, Sustainability, Transformation)**, **Address:** Department of Human Services, 1350 S. King Street, Suite 200, Honolulu, HI 96814, **Phone:** **808-524-3370** (Oahu), **1-800-316-8005** (Neighbor Islands), **TTY:** **711**, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** **medquest.hawaii.gov/**
Idaho	**Idaho Medicaid**, **Address:** Idaho Department of Health and Welfare, PO Box 83720, Boise, ID 83720-0036, **Phone:** **1-888-528-5861**, **1-877-456-1233**, **TTY:** **1-888-791-3004** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **healthandwelfare.idaho.gov/services-programs/medicaid-health**
Illinois	**Illinois Medicaid**, **Address:** Department of Healthcare and Family Services (HFS), Prescott Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763, **Phone:** **1-800-843-6154**, **1-866-468-7543**, **TTY:** **1-877-204-1012** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **hfs.illinois.gov/about/about.html**

	State Medicaid Office
Indiana	**Indiana Medicaid**, **Address:** Family and Social Services Administration, 402 W. Washington Street, Room W392, PO Box 7083, Indianapolis, IN 46204, **Phone:** 1-800-403-0864, 1-800-457-4584, **TTY:** 1-800-743-3333 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** in.gov/fssa/ompp/
Iowa	**Iowa Medicaid**, **Address:** Iowa Department of Health and Human Services, 1305 E Walnut Street, Des Moines, IA 50319-0114, **Phone:** 1-800-338-8366, 515-256-4606, **TTY:** 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.iowa.gov/programs/welcome-iowa-medicaid
Kansas	**KanCare (Kansas' Medicaid program)**, **Address:** KanCare Clearinghouse, PO Box 3599, Topeka, KS 66601, **Phone:** 1-800-792-4884, **TTY:** 711 or 1-800-792-4292 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kancare.ks.gov/
Kentucky	**Kentucky Medicaid**, **Address:** Cabinet for Health and Family Services (CHFS), 275 E. Main St., Frankfort, KY 40621, **Phone:** Member Services: 1-800-635-2570, Eligibility: 1-855-306-8959, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** chfs.ky.gov/agencies/dms/Pages/default.aspx
Louisiana	**Louisiana Medicaid**, **Address:** Louisiana Department of Health, PO Box 629, Baton Rouge, LA 70821-0629, **Phone:** 1-888-342-6207, **TTY:** 1-855-526-3346 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ldh.la.gov/page/about-medicaid
Maine	**MaineCare**, **Address:** Department of Health and Human Services, Office for Family Independence, 114 Corn Shop Lane, Farmington, ME 04938, **Phone:** 1-800-977-6740, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** maine.gov/dhhs/ofi/programs-services/health-care-assistance
Maryland	**Maryland Medicaid**, **Address:** Department of Health, Herbert R. O'Conor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, **Phone:** 1-877-463-3464, 410-767-6500, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** mmcp.health.maryland.gov/Pages/home.aspx
Massachusetts	**MassHealth (Massachusetts' Medicaid program)**, **Address:** 100 Hancock St. 1st Floor Quincy, MA 02171, **Phone:** 1-800-841-2900, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mass.gov/orgs/masshealth
Michigan	**Michigan Medicaid**, **Address:** Health & Human Services, 333 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, **Phone:** 1-800-642-3195, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** michigan.gov/medicaid
Minnesota	**Medical Assistance (MA) (Minnesota's Medicaid program)**, **Address:** Department of Human Services, 540 Cedar Street, Saint Paul, MN 55101, **Phone:** 1-800-657-3739, 651-431-2670, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Mississippi	**Mississippi Division of Medicaid**, **Address:** MS Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201, **Phone:** 1-800-421-2408, 601-359-6050, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.ms.gov/

	State Medicaid Office
Missouri	**Missouri Medicaid (MO HealthNet)**, **Address:** Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, **Phone:** 573-751-3425, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mydss.mo.gov/mhd
Montana	**Montana Medicaid**, **Address:** Department of Public Health and Human Services (DPHHS), 111 North Sanders Street, Helena, MT 59601-4520, PO Box 4210, Helena, MT 59604-4210, **Phone:** 1-800-362-8312 (Member Help Line), 1-888-706-1535 (Eligibility), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
Nebraska	**Nebraska Medicaid**, **Address:** Department of Health and Human Services, 301 Centennial Mall South, Lincoln, NE 68509, **Phone:** 1-855-632-7633 (Eligibility), 402-471-3121 (Division of Medicaid), **TTY:** 1-402-471-7256 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx
Nevada	**Nevada Medicaid**, **Address:** Department of Health and Human Services, PO Box 30042, Reno, NV 89520-3042, **Phone:** 1-877-638-3472, 775-684-3600, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhcfp.nv.gov/Members/Home/
New Hampshire	**New Hampshire Medicaid (Medical Assistance) program**, **Address:** Department of Health & Human Services, Division of Medicaid Services, 129 Pleasant Street, Concord, NH 03301, **Phone:** 1-844-275-3447, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhhs.nh.gov/programs-services/medicaid
New Jersey	**NJ Department of Human Services, Division of Medical Assistance & Health Services**, **Address:** NJ Department of Human Services, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, **Phone:** 1-800-701-0710, **TTY:** 711, **Hours:** Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM, **Website:** state.nj.us/humanservices/dmahs/
New Mexico	**Turquoise Care (New Mexico's Medicaid program)**, **Address:** New Mexico Health Care Authority, PO Box 2348, Santa Fe, NM 87504-2348, **Phone:** 1-800-283-4465, **TTY:** 711, **Hours:** Monday–Friday 7:00 AM to 6:30 PM, **Website:** hsd.state.nm.us/turquoise-care/
New York	**New York State Medicaid**, **Address:** New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, **Phone:** 1-800-541-2831, **TTY:** 1-800-662-1220 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 8:00 PM, Saturday 9:00 AM to 1:00 PM, **Website:** health.ny.gov/health_care/medicaid/
North Carolina	**NC Medicaid, Division of Health Benefits**, **Address:** 2501 Mail Service Center, Raleigh, NC 27699-2501, **Phone:** 1-888-245-0179, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicaid.ncdhhs.gov/
North Dakota	**North Dakota Medicaid**, **Address:** Medical Services Division, North Dakota Health and Human Services, 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250, **Phone:** 1-800-755-2604, 701-328-7068, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.nd.gov/healthcare/medicaid

	State Medicaid Office
Northern Mariana Islands	**Northern Mariana Islands Medical Assistance for the Needy (MAN) Program**, **Address:** Commonwealth Medicaid Agency, Government Building No. 1252, Capitol Hill Rd., Caller Box 10007 Saipan MP 96950, **Phone:** 670-664-4880, 670-664-4882, 670-664-4886, 670-664-4887, 670-664-4888 (Eligibility), 670-664-4883, 670-664-4884 (Claims), **TTY:** 711, **Hours:** Monday–Thursday 7:30 AM to 1:00 PM, Closed on Fridays and holidays, **Website:** medicaid.cnmi.mp/
Ohio	**Ohio Medicaid**, **Address:** Ohio Department of Medicaid, 50 W. Town Street, Suite 400, Columbus, OH 43215, **Phone:** 1-800-324-8680, **TTY:** 711, **Hours:** Monday–Friday 7:00 AM to 8:00 PM, Saturday 8:00 AM to 5:00 PM, **Website:** medicaid.ohio.gov/
Oklahoma	**SoonerCare**, **Address:** Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, **Phone:** 1-800-987-7767, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oklahoma.gov/ohca.html
Oregon	**Oregon Health Plan (OHP)**, **Address:** PO Box 14015, Salem, OR 97309, **Phone:** 1-800-273-0557, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oregon.gov/oha/hsd/ohp/Pages/index.aspx
Pennsylvania	**Community HealthChoices**, **Address:** Office of Medical Assistance Programs (OMAP) Health and Human Services Building Room 515 PO Box 2675 Harrisburg, PA 17105, **Phone:** 1-800-692-7462, 1-866-550-4355, **TTY:** 711 or 1-800-451-5886 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 4:45 PM, **Website:** pa.gov/agencies/dhs/resources/medicaid/chc
Puerto Rico	**Medicaid Program**, **Address:** Department Of Health, PO Box 70184, San Juan, PR 00936-8184, **Phone:** 787-641-4224, **TTY:** 787-625-6955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday-Friday 8:00 AM to 6:00 PM, **Website:** medicaid.pr.gov
Rhode Island	**Rhode Island Executive Office of Health and Human Services (EOHHS)**, **Address:** PO Box 8709, Cranston, RI 02920-8787, **Phone:** 1-855-697-4347, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 3:00 PM, **Website:** eohhs.ri.gov/consumer/health-care
South Carolina	**Healthy Connections (South Carolina's Medicaid program)**, **Address:** Department of Health and Human Services (SCDHHS), PO Box 8206, Columbia, SC 29202-8206, **Phone:** 1-888-549-0820, **TTY:** 1-888-842-3620 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** scdhhs.gov/
South Dakota	**South Dakota Medicaid**, **Address:** Department of Social Services, 700 Governors Drive, Pierre, SD 57501, **Phone:** 1-800-597-1603, 605-773-3495, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dss.sd.gov/medicaid/
Tennessee	**TennCare Medicaid (Tennessee's Medicaid program)**, **Address:** 310 Great Circle Road, Nashville, TN 37243, **Phone:** 1-855-259-0701 (Applications), 1-800-342-3145 (General), **TTY:** 1-877-779-3103 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 6:00 PM, **Website:** tn.gov/tenncare

	State Medicaid Office
Texas	**Texas Medicaid Program**, **Address:** Health and Human Services (HHS), North Austin Complex, 4601 W. Guadalupe St., Austin, TX 78751-3146, PO Box 13247, Austin, Texas 78711-3247, **Phone:** 1-800-252-8263, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** hhs.texas.gov/services/health/medicaid-chip
U.S. Virgin Islands	**Virgin Islands Medicaid Program**, **Address:** Department of Human Services, 1303 Hospital Ground, Knud Hansen Complex/Building A, St. Thomas, VI 00802; 3012 Golden Rock, Christiansted, St. Croix, VI 00820, **Phone:** DHS Head Quarters in St. John, Cruz Bay, St. John: 340-715-6929 (Customer Support), 340-774-0930 (St. Thomas), 340-718-2980 (St. Croix), 340-776-6334 (St. John), **TTY:** 711, **Hours:** Monday–Friday 7:00 AM to 7:00 PM, **Website:** dhs.vi.gov/office-of-medicaid/
Utah	**Utah Medicaid**, **Address:** Department of Health and Human Services, Cannon Health Building, PO Box 143106, Salt Lake City, UT 84114-3106, **Phone:** 1-800-662-9651, 801-538-6155 (Customer Service); 801-526-0950, 1-866-435-7414 (Eligibility), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM MST (Tuesday hours are 11:00 AM to 5:00 PM), **Website:** medicaid.utah.gov/
Vermont	**Vermont Medicaid Programs**, **Address:** Agency of Human Services, Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, **Phone:** 1-800-250-8427, **TTY:** 711, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** dvha.vermont.gov/members
Virginia	**Virginia Medicaid**, **Address:** Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, **Phone:** 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), **TTY:** 1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, **Website:** dmas.virginia.gov/
Virginia	**Cardinal Care**, **Address:** Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, **Phone:** 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), **TTY:** 1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, **Website:** dmas.virginia.gov/ Questions can also be submitted online at ask.vamedicaid.dmas.virginia.gov/ask-va-medicaid#/. This is Virginia Medicaid's online request portal. That website also provides answers to frequently asked questions about Virginia Medicaid.
Washington	**Washington Apple Health**, **Address:** Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501, **Phone:** 1-800-562-3022, **TTY:** 711, **Hours:** Monday–Friday 7:00 AM to 5:00 PM, **Website:** hca.wa.gov/
West Virginia	**West Virginia Medicaid program**, **Address:** Department of Health and Human Resources, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3709, **Phone:** 1-877-716-1212, 304-558-1700, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** dhhr.wv.gov/bms/Pages/default.aspx

	State Medicaid Office
Wisconsin	**Wisconsin Medicaid**, **Address:** Department of Health Services, 1 West Wilson Street, Madison, WI 53703, **Phone:** 1-800-362-3002, 608-266-1865, **TTY:** 711 or 800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** dhs.wisconsin.gov/medicaid/index.htm
Wyoming	**Wyoming Medicaid**, **Address:** Wyoming Department of Health P.O. Box 1248 Cheyenne, WY 82003-1248, **Phone:** 1-855-294-2127, **TTY:** 1-855-329-5205 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 6:00 PM, **Website:** wyomingmedicaid.com

	State Health Insurance Assistance Program (SHIP)
Alabama	**Alabama State Health Insurance Assistance Program**, **Address:** RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, **Phone:** 1-800-243-5463, 334-242-5743, **TTY:** 1-800-253-0799 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** alabamaageline.gov/ship/
Alaska	**Alaska Medicare Information Office**, **Address:** Department of Health, 1835 Bragaw Street, Suite 350, Anchorage, AK 99508, **Phone:** 1-800-478-6065, 907-269-3680, **TTY:** 1-800-770-8973 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** medicare.alaska.gov
Arizona	**Arizona State Health Insurance Assistance Program**, **Address:** Department of Economic Security, Division of Aging and Adult Services, 1789 W. Jefferson Street, Phoenix, AZ 85007, **Phone:** 1-800-432-4040, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** azship.org/
Arkansas	**Arkansas Seniors Health Insurance Information Program (AR SHIIP)**, **Address:** 1 Commerce Way, Little Rock, AR 72202, **Phone:** 1-800-224-6330, **TTY:** 501-683-4468 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** insurance.arkansas.gov/consumer-services/senior-health/
California	**California Health Insurance Counseling and Advocacy Program (HICAP)**, **Address:** Department of Aging, 2880 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, **Phone:** 1-800-434-0222, **TTY:** 1-800-735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.ca.gov/hicap/
Colorado	**Colorado Senior Health Care & Medicare Assistance (SHIP & SMP)**, **Address:** Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202, **Phone:** 1-888-696-7213, 1-800-503-5190, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare

	State Health Insurance Assistance Program (SHIP)
Connecticut	**Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES)**, **Address:** Department of Aging and Disability Services, 55 Farmington Ave., 12th Floor, Hartford, CT 06105, **Phone:** 1-800-994-9422, **TTY:** 1-860-247-0775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** portal.ct.gov/ADS-CHOICES
Delaware	**Delaware Medicare Assistance Bureau (DMAB)**, **Address:** Department of Insurance, 1351 West North Street, Suite 101, Dover, DE 19904, **Phone:** 1-800-336-9500, 302-674-7364, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** insurance.delaware.gov/divisions/dmab/
District of Columbia	**Health Insurance Counseling Project (HICP)**, **Address:** Department of Aging and Community Living, 250 E Street SW, Washington, DC 20024, **Phone:** 202-727-8370, **TTY:** 711, **Hours:** Monday–Friday 9:30 AM to 4:30 PM, **Website:** dacl.dc.gov/service/health-insurance-counseling
Florida	**Serving Health Insurance Needs of Elders (SHINE) (Florida SHIP)**, **Address:** Department of Elder Affairs, 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, **Phone:** 1-800-963-5337, **TTY:** 1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridashine.org/
Georgia	**Georgia SHIP**, **Address:** Department of Human Services, Division of Aging Services, 47 Trinity Ave. S.W., Atlanta, GA 30334, **Phone:** 1-866-552-4464 (Option 4), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.georgia.gov/georgia-ship
Guam	**Guam State Health Insurance Assistance Program (SHIP)**, **Address:** Guam Department of Public Health and Social Services, 123 Chalan Kareta, Mangilao, Guam 96913-6304, **Phone:** 671-735-7415, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphss.guam.gov
Hawaii	**Hawaii SHIP**, **Address:** State Department of Health, Executive Office on Aging, No. 1 Capitol District, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, **Phone:** 1-888-875-9229, 808-586-7299, **TTY:** 1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** hawaiiship.org/
Idaho	**Idaho Senior Health Insurance Benefits Advisors (SHIBA)**, **Address:** Department of Insurance, 700 W. State Street, 3rd Floor, PO Box 83720, Boise, ID 83720-0043, **Phone:** 1-800-247-4422, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, except state holidays, **Website:** doi.idaho.gov/SHIBA/
Illinois	**Senior Health Insurance Program (Illinois SHIP)**, **Address:** Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, **Phone:** 1-800-252-8966, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** ilaging.illinois.gov/ship.html
Indiana	**Indiana State Health Insurance Assistance Program**, **Address:** Department of Insurance, 311 W. Washington Street, Indianapolis, IN 46204, **Phone:** 1-800-452-4800, **TTY:** 1-866-846-0139 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** in.gov/ship/

	State Health Insurance Assistance Program (SHIP)
Iowa	**Iowa Senior Health Insurance Information Program (SHIIP)**, **Address:** Insurance Division, 1963 Bell Ave., Suite 100, Des Moines, IA 50315, **Phone:** 1-800-351-4664, **TTY:** 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** shiip.iowa.gov/
Kansas	**Senior Health Insurance Counseling for Kansas (SHICK)**, **Address:** Department for Aging and Disability Services, New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, **Phone:** 1-800-860-5260, **TTY:** 785-291-3167 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick
Kentucky	**Kentucky State Health Insurance Assistance Program**, **Address:** Cabinet for Health and Family Services, 275 E. Main Street, 3E-E, Frankfort, KY 40601, **Phone:** 1-877-293-7447 (Option 2), 502-564-6930, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dail/Pages/ship.aspx
Louisiana	**Louisiana Senior Health Insurance Information Program (SHIIP)**, **Address:** Department of Insurance, 1702 N. Third Street, PO Box 94214, Baton Rouge, LA 70802, **Phone:** 1-800-259-5300, 225-342-5301, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ldi.la.gov/consumers/senior-health-shiip
Maine	**Maine State Health Insurance Assistance Program**, **Address:** Department of Health and Human Services, Office of Aging and Disability Services, 11 State House Station, 41 Anthony Avenue, Augusta, ME 04333, **Phone:** 1-800-262-2232, 207-287-9200, **TTY:** 711, **Hours:** Monday–Thursday 9:00 AM to 5:00 PM, Friday 9:00 AM to 4:00 PM, **Website:** maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
Maryland	**Maryland State Health Insurance Assistance Program**, **Address:** Maryland Department of Aging, 36 S Charles Street, 12th Floor Baltimore, Maryland 21201, **Phone:** 1-800-243-3425, 410-767-1100, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.maryland.gov/Pages/state-health-insurance-program.aspx
Massachusetts	**SHINE (Serving Health Insurance Needs of Everyone) (Massachusetts SHIP)**, **Address:** Executive Office of Aging & Independence, 1 Ashburton Place, 5th Floor, Boston, MA 02108, **Phone:** 1-800-243-4636, **TTY:** 1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mass.gov/health-insurance-counseling
Michigan	**Michigan Medicare Assistance Program (MMAP)**, **Address:** Department of Health & Human Services, 235 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, **Phone:** 1-800-803-7174 or 1-800-975-7630, **TTY:** 1-888-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM, **Website:** michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program
Minnesota	**Minnesota's Senior LinkAge Line**, **Address:** Elmer L. Anderson Human Services, 540 Cedar Street, St. Paul, MN 55164, **Phone:** 1-800-333-2433, **TTY:** 1-800-627-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00AM to 4:30 PM, **Website:** mn.gov/senior-linkage-line/

	State Health Insurance Assistance Program (SHIP)
Mississippi	**Mississippi State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Human Services, Division of Aging and Adult Services, 200 South Lamar St., Jackson, MS 39201, **Phone:** 1-844-822-4622, 601-709-0624, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mdhs.ms.gov/aging/finding-services-for-older-adults/
Missouri	**Missouri SHIP**, **Address:** Department of Commerce & Insurance, 601 W. Nifong Blvd., Ste. A, Columbia, MO 65203-6804, **Phone:** 1-800-390-3330, **TTY:** 1-800-735-2966 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 9:00 AM to 4:00 PM, **Website:** missouriship.org
Montana	**Montana State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Public Health and Human Services, Senior and Long Term Care Division, 1100 N Last Chance Gulch, 4th Floor, Helena MT 59601, **Phone:** 1-800-551-3191, 406-444-4077, **TTY:** 1-800-833-8503 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/sltc/aging/ship
Nebraska	**Nebraska SHIP**, **Address:** Department of Insurance, 1526 K Street, Suite 201, Lincoln, NE 68508, **Phone:** 1-800-234-7119, **TTY:** 1-800-833-7352 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** doi.nebraska.gov/ship-smp
Nevada	**Nevada State Health Insurance Assistance Program (SHIP)**, **Address:** Aging and Disability Service Division Administrative Office, 1550 College Parkway Carson City, NV 89706, **Phone:** 1-800-307-4444, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_(MAP)/MAP_Prog/
New Hampshire	**ServiceLink (New Hampshire SHIP)**, **Address:** Department of Health & Human Services, Brown Building, 129 Pleasant Street, Concord, NH 03301, **Phone:** 1-866-634-9412, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** servicelink.nh.gov
New Jersey	**New Jersey State Health Insurance Assistance Program (SHIP)**, **Address:** State Health Insurance Assistance Program, Division of Aging Services, PO Box 807, Trenton, NJ 08625, **Phone:** 1-800-792-8820, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** nj.gov/humanservices/doas/services/q-z/ship/index.shtml
New Mexico	**New Mexico State Health Insurance Assistance Program (SHIP)**, **Address:** New Mexico Aging & Long-Term Services Department, 2550 Cerrillos Road, Santa Fe, NM 87505, **Phone:** 1-800-432-2080, **TTY:** 505-476-4937 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.nm.gov
New York	**Health Insurance Information, Counseling and Assistance (HIICAP)**, **Address:** 2 Empire State Plaza, 5th Floor, Albany, NY 12223, **Phone:** 1-800-701-0501, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.ny.gov/health-insurance-information-counseling-and-assistance

	State Health Insurance Assistance Program (SHIP)
North Carolina	**Medicare and Seniors' Health Insurance Information Program (SHIIP) (North Carolina SHIP)**, **Address:** Department of Insurance, 3200 Beechleaf Court, Raleigh NC 27604, **Phone:** 1-855-408-1212, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
North Dakota	**North Dakota State Health Insurance Assistance Program (SHIP)**, **Address:** Insurance Department, 600 E. Boulevard Ave., 5th Floor, Bismarck, ND 58505-0320, **Phone:** 1-888-575-6611, **TTY:** 1-800-366-6888 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Thursday 8:00 AM to 5:00 PM, Friday 8:00 AM to 12:00 PM, **Website:** insurance.nd.gov/shic-medicare
Ohio	**Ohio Senior Health Insurance Information Program (OSHIIP)**, **Address:** Department of Insurance, 50 W. Town Street, Third Floor, Suite 300, Columbus, OH 43215, **Phone:** 1-800-686-1578, **TTY:** 711, **Hours:** Monday–Friday 7:30 AM to 5:00 PM, **Website:** insurance.ohio.gov/about-us/divisions/oshiip
Oklahoma	**Oklahoma State Health Insurance Counseling Program (SHIP)**, **Address:** Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105, **Phone:** 1-800-763-2828, 405-521-2828, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oid.ok.gov/consumers/information-for-seniors/
Oregon	**Oregon Senior Health Insurance Benefits Assistance (SHIBA)**, **Address:** Department of Consumer and Business Services 350 Winter Street, NE, Room 330 Salem OR 97309-0405, **Phone:** 1-800-722-4134, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** shiba.oregon.gov/
Pennsylvania	**Pennsylvania Medicare Education and Decision Insight (PA MEDI)**, **Address:** Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, **Phone:** 1-800-783-7067, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling.html
Puerto Rico	**Programa Estatal de Asistencia Sobre Seguros de Salud (SHIP: State Health Insurance Assistance Program)**, **Address:** Oficina del Procurador de las Personas de Edad Avanzada, Oficina Central, Avenida Ponce de León, Parada 16 Edificio 1064 tercer piso, Santurce (altos del edificio de Marshalls), San Juan, PR 00919-1179, **Phone:** 1-800-981-0056 (Mayaguez); 1-800-981-7735 (Ponce); 1-877-725-4300 (San Juan), **TTY:** 787-919-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx
Rhode Island	**Rhode Island State Health Insurance Assistance Program (SHIP)**, **Address:** Office of Healthy Aging, 25 Howard Ave., Building 57, Cranston, RI 02920, **Phone:** 1-888-884-8721, **TTY:** 401-462-0740 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oha.ri.gov/Medicare
South Carolina	**Insurance Counseling Assistance and Referrals for Elders (I-Care) Program (South Carolina SHIP)**, **Address:** Department on Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201, **Phone:** 1-800-868-9095, **TTY:** 1-888-842-3620 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** getcaresc.com/guide/insurance-counseling-medicaremedicaid

	State Health Insurance Assistance Program (SHIP)
South Dakota	**Senior Health Information and Insurance Education (SHIINE) (South Dakota SHIP)**, **Address:** Department of Human Services, Division of Long Term Services and Support, 3800 E Hwy 34 - Hillsview Plaza, c/o 500 E. Capitol Avenue, Pierre, SD 57501, **Phone:** 1-800-536-8197 (Southeastern SD), 1-877-286-9072 (Western SD), 1-605-432-8801 (Northeastern SD), **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 4:30 PM, **Website:** dhs.sd.gov/en/ltss/shiine
Tennessee	**Tennessee State Health Insurance Assistance Program (SHIP)**, **Address:** Commission on Aging and Disability, Andrew Jackson Bldg., 9th Floor, 502 Deaderick Street, Nashville, TN 37243, **Phone:** 1-877-801-0044, **TTY:** 1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tnmedicarehelp.com/
Texas	**Texas Health Information, Counseling and Advocacy Program (HICAP)**, **Address:** Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin TX 78751, **Phone:** 1-800-252-9240, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/medicare
U.S. Virgin Islands	**Virgin Islands State Health Insurance Assistance Program (VISHIP)**, **Address:** 1131 King Street, Ste. 101, Christiansted, St. Croix, VI 00820; 5049 Kongens Gode, St. Thomas, VI 00802, **Phone:** 340-773-6449 (St. Croix), 340-774-2991 (St. Thomas/St. John), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ltg.gov.vi/departments/vi-ship-medicare/
Utah	**Utah Senior Health Insurance Information Program (SHIP)**, **Address:** Department of Human Services 195 North 1950 West Salt Lake City UT 84116, **Phone:** 1-800-541-7735, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** daas.utah.gov/seniors/
Vermont	**Vermont State Health Insurance Assistance Program (SHIP)**, **Address:** Vermont Association of Area Agencies on Aging 476 Main Street, Suite #3 Winooski VT 05404, **Phone:** 1-800-642-5119, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** asd.vermont.gov/services/ship
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)**, **Address:** Division for Aging Services, 1610 Forest Ave., Suite 100, Henrico, VA 23229, **Phone:** 1-800-552-3402, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** www.vda.virginia.gov/vicap.htm
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)**, **Address:** Division for Aging Services, 1610 Forest Ave., Suite 100, Henrico, Virginia 23229, **Phone:** 1-800-552-3402, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** www.vdh.virginia.gov/disease-prevention/vamap/
Washington	**Washington Statewide Health Insurance Benefits Advisors (SHIBA)**, **Address:** Office of the Insurance Commissioner, PO Box 40255, Olympia, WA 98504-0255, **Phone:** 1-800-562-6900, **TTY:** 360-586-0241 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** insurance.wa.gov/insurance-resources/medicare
West Virginia	**West Virginia State Health Insurance Assistance Program (WV SHIP)**, **Address:** Bureau of Senior Services, 1900 Kanawha Blvd. East, (3rd Floor Town Center Mall) Charleston, WV 25305, **Phone:** 304-558-3317, 877-987-4463, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** wvship.org/

	State Health Insurance Assistance Program (SHIP)
Wisconsin	**Wisconsin State Health Insurance Assistance Program (SHIP)**, **Address:** Department of Health Services, 1 W. Wilson Street, Madison, WI 53703, **Phone:** 1-800-242-1060, **TTY:** 711 or 262-347-3045 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
Wyoming	**Wyoming State Health Insurance Information Program (WSHIIP)**, **Address:** Wyoming Dept. of Insurance, 106 W. Adams Ave., Riverton, WY 82501, **Phone:** 1-800-856-4398, **TTY:** 711, **Hours:** Monday–Friday 7:00 AM to 4:00 PM, **Website:** wyomingseniors.com/

	State Pharmaceutical Assistance Program (SPAP)
Alabama	**Alabama SenioRx Prescription Assistance Program**, **Address:** Department of Senior Services, RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, **Phone:** 1-800-243-5463, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** alabamaageline.gov/seniorx/
Alaska	**Alaska Senior Benefits Program**, **Address:** Alaska Senior Benefits Program 3601 C Street, Suite 902 Anchorage, Alaska 99503 350 Main Street, Suite 404 Juneau, AK 99811, **Phone:** 1-800-478-7778, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** health.alaska.gov/en/services/division-of-public-assistance-dpa-services/senior-benefits-program/
Delaware	**Delaware Prescription Assistance Program**, **Address:** DXC DPAP, PO Box 950, New Castle, DE 19720-0950, **Phone:** 1-844-245-9580, **TTY:** 1-800-232-5470 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dhss/dmma/dpap.html
Delaware	**Delaware Chronic Renal Disease Program**, **Address:** 253 NE Front Street, Milford, DE 19963, **Phone:** 302-424-7180, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dhss/dmma/crdprog.html
Indiana	**HoosierRx**, **Address:** 402 W. Washington, Room 372, Indianapolis, IN 46204, **Phone:** 1-866-267-4679, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 4:30 PM, **Website:** IN.gov/HoosierRx
Kentucky	**Kentucky Prescription Assistance Program (KPAP)**, **Address:** 275 East Main Street, HS1W-B, Frankfort, KY 40621, **Phone:** 1-800-633-8100, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** chfs.ky.gov/agencies/dph/dpqi/hcab/Pages/kpap.aspx
Massachusetts	**Prescription Advantage**, **Address:** PO Box 15153, Worcester, MA 01615-0153, **Phone:** 1-800-243-4636, **TTY:** 1-877-610-0241 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mass.gov/prescription-drug-assistance
Maryland	**Maryland Senior Prescription Drug Assistance Program (SPDAP)**, **Address:** Maryland – SPDAP c/o International Software Systems Inc., PO Box 749, Greenbelt, Maryland 20768-0749, **Phone:** 1-800-551-5995, **TTY:** 1-800-877-5156 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** marylandspdap.com/

	State Pharmaceutical Assistance Program (SPAP)
Maine	**MaineCare Rx Plus**, **Address:** Department of Human Services, 13 Prescott Drive Machias, Maine 04654, **Phone:** 1-866-796-2463, **TTY:** 207-287-1828 or 1-800-423-4331 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 4:00 PM, **Website:** maine.gov/dhhs/mecdc/infectious-disease/hiv-std/provider/documents/maine-rx-plus-application.pdf
Missouri	**Missouri Rx Plan (MORx)**, **Address:** PO Box 2700, Jefferson City, MO 65102, **Phone:** 1-800-375-1406, 573-751-6963, **TTY:** 1-800-735-2966 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 6:00 AM to 6:00 PM, **Website:** mydss.mo.gov/mhd/morx-general-faqs#:
Montana	**Montana Big Sky Rx Program**, **Address:** PO Box 202915, Helena, MT 59620-2915, **Phone:** 1-866-369-1233, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/SLTC/aging/BigSky
New Jersey	**New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD)**, **Address:** PAAD-HAAAD, Department of Human Services, PO Box 715, Trenton, NJ 08625-0715, **Phone:** 1-800-792-9745, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nj.gov/humanservices/doas/services/l-p/paad/
New Jersey	**New Jersey Senior Gold Prescription Discount Program**, **Address:** Division of Aging Services, PO Box 715, Trenton, NJ 08625-0715, **Phone:** 1-800-792-9745, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nj.gov/humanservices/doas/services/q-z/senior-gold/
New Mexico	**New Mexico Medical Insurance Pool (NMMIP)**, **Address:** PO 780548, San Antonio, TX 78278, **Phone:** 1-866-306-1882, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nmmip.org
New York	**Elderly Pharmaceutical Insurance Coverage (EPIC) Program**, **Address:** EPIC, PO Box 15018, Albany, NY 12212-5108, **Phone:** 1-800-332-3742, **TTY:** 1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.ny.gov/health_care/epic/
Oklahoma	**RX for Oklahoma**, **Address:** Oklahoma State Department of Health, 123 Robert S. Kerr Ave., Ste. 1702, Oklahoma City, OK 73102-6406, **Phone:** 1-877-794-6552, 405-243-2939, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oklahoma.gov/health/health-education/community-outreach/community-health/nursing-service/rx-for-oklahoma-prescription-assistance.html
Pennsylvania	**Pharmaceutical Assistance Contract for the Elderly (PACE)/PACE Needs Enhancement Tier (PACENET)**, **Address:** PACE/PACENET, PO Box 8806, Harrisburg, PA 17105-8806, **Phone:** 1-800-225-7223, **TTY:** 1-800-222-9004 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking , **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
Pennsylvania	**Special Pharmaceutical Benefits Program - Mental Health, Address:** Department of Human Services - OMHSAS, Business Partner Support Unit - SPBP-MH Program, Commonwealth Tower, 12th Floor, PO Box 2675, Harrisburg, PA 17105-2675, **Phone:** 1-877-356-5355 Option 3, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** pa.gov/agencies/dhs.html

	State Pharmaceutical Assistance Program (SPAP)
Pennsylvania	**Chronic Renal Disease Program (CRDP)**, **Address:** The Chronic Renal Disease Program, Pennsylvania Department of Health, Division of Child and Adult Health Services, 625 Forster St., 7th Floor East Wing, Harrisburg, PA 17120-0701, **Phone:** 1-800-225-7223, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** health.pa.gov/topics/programs/Chronic-Renal-Disease
Rhode Island	**RI Pharmaceutical Assistance to Elders (RIPAE)**, **Address:** RI Office of Health Aging, 25 Howard Avenue, Louis Pasteur Bldg., #57 Cranston, RI 02920, **Phone:** 401-462-3000, 401-462-0560, **TTY:** 401-462-0740 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance
Texas	**Kidney Health Care Program (KHC)**, **Address:** Kidney Health Care, MC 1938, PO Box 149030, Austin, TX 78714-9947, **Phone:** 1-800-222-3986, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/kidney-health-care
Vermont	**VPharm and Healthy Vermonters Programs**, **Address:** Green Mountain Care, Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500, **Phone:** 1-800-250-8427, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** dvha.vermont.gov/members/prescription-assistance
Wisconsin	**SeniorCare**, **Address:** Senior Care, PO Box 6710, Madison, WI 53716-0710, **Phone:** 1-800-657-2038, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** dhs.wisconsin.gov/seniorcare/index.htm

	State AIDS Drug Assistance Programs (ADAP)
Alabama	**Alabama AIDS Drug Assistance Program (ADAP)**, **Address:** Office of HIV Prevention and Care, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104, **Phone:** 1-866-574-9964, 1-512-776-7150, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** alabamapublichealth.gov/hiv/adap.html
Alaska	**Alaska AIDS Drug Assistance Program (ADAP)**, **Address:** Anchorage – 1057 W. Fireweed Lane, Suite 102, Anchorage, AK 99503, **Phone:** 1-800-478-AIDS (1-800-478-2437), Anchorage: 907-263-2050, Juneau: 907-500-7465, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** alaskanaids.org/index.php/contact
Arizona	**Arizona AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health Services, 150 N. 18th Ave., Suite 280, Phoenix, AZ 85007, **Phone:** 1-800-334-1540, 602-364-3610, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** azadap.com
Arkansas	**Ryan White Program, Arkansas AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 4815 W. Markham, Little Rock, AR 72205, **Phone:** 1-800-462-0599 (Option 3), 501-661-2408, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** healthy.arkansas.gov/programs-services/topics/ryan-white-program
California	**California AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, Office of AIDS, MS 7700, PO Box 997426, Sacramento, CA 95899-7426, **Phone:** 1-844-421-7050, 916-558-1784, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** cdph.ca.gov/Programs/CID/DOA/pages/oaadap.aspx

	State AIDS Drug Assistance Programs (ADAP)
Colorado	**Colorado State Drug Assistance Program (SDAP)**, **Address:** Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, CO 80246, **Phone:** 303-692-2716, 303-692-2000, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** cdphe.colorado.gov/state-drug-assistance-program
Connecticut	**Connecticut AIDS Drug Assistance Program (CADAP)**, **Address:** Department of Public Health c/o Magellan Rx Management, PO Box 13001, Albany, NY 12212-3001, **Phone:** 1-800-424-3310, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ct.enroll.lh.primetherapeutics.com/
Delaware	**Delaware AIDS Drug Assistance Program (ADAP)**, **Address:** Division of Public Health (DPH), Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901, **Phone:** 302-744-1050, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dph/dpc/hivtreatment.html
District of Columbia	**DC Pharmacy Benefits Program**, **Address:** Department of Health, 2201 Shannon Place SE, Washington, DC 20020, **Phone:** 202-671-4815, **TTY:** 711, **Hours:** Monday–Friday 8:15 AM to 4:45 PM, **Website:** dchealth.dc.gov/Pharmacy_Benefits_Program
Florida	**Florida AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, **Phone:** 1-800-352-2437, 844-381-2327, 850-245-4422, **TTY:** 1-888-503-7118 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridahealth.gov/diseases-and-conditions/aids/adap/
Georgia	**Georgia AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, 200 Piedmont Avenue, SE, Atlanta, GA 30334, **Phone:** 404-656-9805, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Hawaii	**Hawaii HIV Drug Assistance Program (HDAP)**, **Address:** State Department of Health Harm Reduction Services Branch, 3627 Kilauea Ave., Suite 306, Honolulu, HI 96816, **Phone:** 808-733-9362, 808-733-9361, 808-733-9360, **TTY:** 711, **Hours:** Monday–Friday 7:45 AM to 2:30 PM, **Website:** health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/
Idaho	**Idaho AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Welfare, Division of Public Health, 450 W. State Street, PO Box 83720, Boise, ID 83702, **Phone:** 208-985-3019, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv
Illinois	**Illinois AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, Medication Assistance Program,525 W. Jefferson Street, 1st Floor, Springfield, IL 62761, **Phone:** 1-800-825-3518, 1-800-243-2437, **TTY:** 1-800-547-0466, **Hours:** Monday–Friday 9:00 AM to 4:00 PM, **Website:** dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services
Indiana	**Indiana AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 2 N. Meridian Street, Suite C, Indianapolis, IN 46204, **Phone:** 1-866-588-4948 (Option 1), **TTY:** 711, **Hours:** Monday–Friday 8:15 AM to 4:45 PM, **Website:** in.gov/health/hiv-std-viral-hepatitis/hiv-services/

	State AIDS Drug Assistance Programs (ADAP)
Iowa	**Iowa AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health, 321 E. 12th Street, Des Moines, IA 50319-0075, **Phone:** 515-204-3746, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** hhs.iowa.gov/
Kansas	**Kansas AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Environment, Division of Public Health, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, **Phone:** 785-296-6174, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** kdhe.ks.gov/359/AIDS-Drug-Assistance-Program
Kentucky	**Kentucky AIDS Drug Assistance Program (KADAP)**, **Address:** Department of Public Health, 275 East Main Street, HS2E-C, Frankfort, KY 40621, **Phone:** 1-800-420-7431, 502-564-6539, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dph/dehp/hab/pages/services.aspx
Louisiana	**Louisiana Health Access Program (LA HAP)**, **Address:** Department of Health, 1450 Poydras Street, Suite 2136, New Orleans, LA 70112, **Phone:** 504-568-7474, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** lahap.org/
Maine	**Maine AIDS Drug Assistance Program (ADAP)**, **Address:** 40 State House Station Augusta, ME 04330 United States, **Phone:** 207-287-3747, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml
Maryland	**Maryland AIDS Drug Assistance Program (MADAP)**, **Address:** Department of Health, 1223 W. Pratt Street, Baltimore, MD 21223, **Phone:** 1-800-205-6308, 410-767-6535, **TTY:** 1-800-735-2258 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
Massachusetts	**Massachusetts HIV/AIDS Drug Assistance Program (HDAP)**, **Address:** Community Resource Initiative, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129, **Phone:** 1-800-228-2714, 617-502-1700, **TTY:** 1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking., **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** crihealth.org/drug- assistance/hdap/
Michigan	**Michigan Drug Assistance Program (MIDAP)**, **Address:** Department of Health and Human Services, PO Box 30727 Lansing, MI 48909, **Phone:** 1-888-826-6565, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** michigan.gov/dap
Minnesota	**Minnesota Aids Drug Assistance Program**, **Address:** Minnesota Department of Human Services, PO Box 64972, St. Paul, MN 55164-0972, **Phone:** 1-800-657-3761, 651-431-2398, 651-431-2414, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/
Mississippi	**Mississippi AIDS Drug Assistance Program (ADAP)**, **Address:** State Department of Health, PO Box 1700, Jackson, MS 39215, **Phone:** 1-888-343-7373, 601-362-4879, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** msdh.ms.gov/msdhsite/_static/14,13047,150.html
Missouri	**Missouri AIDS Drug Assistance Program**, **Address:** Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102, **Phone:** 573-751-6439, 1-888-252-8045, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

	State AIDS Drug Assistance Programs (ADAP)
Montana	**Montana AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Public Health and Human Services, Cogswell Building, Room C-211, 1400 Broadway, Helena, MT 59620, **Phone:** 406-444-3565, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
Nebraska	**Nebraska AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health & Human Services, PO Box 95026, Lincoln, NE 68509-5026, **Phone:** 402-471-2101, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhs.ne.gov/Pages/HIV-Care.aspx
Nevada	**Nevada AIDS Drug Assistance Program (ADAP)/Nevada Medication Assistance Program (NMAP)**, **Address:** Department of Health and Human Services, 2290 S. Jones Blvd., Las Vegas, Nevada 89146, **Phone:** 702-486-0768, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** endhivnevada.org/adap-nmap/
New Hampshire	**New Hampshire AIDS Drug Assistance Program**, **Address:** Department of Health & Human Services, 29 Hazen Drive, Concord, NH 03301, **Phone:** 603-271-4502, 603-271-4496, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids
New Jersey	**New Jersey AIDS Drug Distribution Program (ADDP)**, **Address:** Department of Health, PO Box 360, Trenton, NJ 08625-0360, **Phone:** 1-877-613-4533, 1-800-624-2377, **TTY:** 711, **Hours:** 24 hours a day, 7 days a week, **Website:** nj.gov/health/hivstdtb/hiv-aids/medications.shtml
New Mexico	**New Mexico AIDS Drug Assistance Program (ADAP)**, **Address:** Homestead Office 5300 Homestead NE, Suite 110, Albuquerque, NM 87110, **Phone:** 505-709-7618, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** nmhealth.org/about/phd/idb/hats/
New York	**New York AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, Uninsured Care Programs, Empire Station, PO Box 2052, Albany, NY 12220-0052, **Phone:** 1-800-542-2437, 1-844-682-4058, 518-459-1641, **TTY:** 518-459-0121 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** health.ny.gov/diseases/aids/general/resources/adap/
North Carolina	**North Carolina HIV Medication Assistance Program (NC HMAP)**, **Address:** Department of Health and Human Services, 1907 Mail Service Center, Raleigh, NC 27699-1907, **Phone:** 1-877-466-2232, 919-733-9161, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** epi.dph.ncdhhs.gov/cd/hiv/hmap.html
North Dakota	**North Dakota AIDS Drug Assistance Program (ADAP)**, **Address:** Ryan White Program Part B, North Dakota Dept. of Health, Division of Disease Control, 2635 East Main Ave., Bismarck, ND 58506-5520, **Phone:** 1-800-472-2622, 701-328-2310, **TTY:** 711 or 1-800-366-6888 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking., **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ndhealth.gov/hiv/RyanWhite

	State AIDS Drug Assistance Programs (ADAP)
Ohio	**Ohio HIV Drug Assistance Program (OHDAP)**, **Address:** Department of Health, 246 N. High Street, Columbus, OH 43215, **Phone:** 1-800-777-4775, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
Oklahoma	**Oklahoma AIDS Drug Assistance Program (ADAP)**, **Address:** State Department of Health, Sexual Health and Harm Reduction Services, 123 Robert S. Kerr Avenue, Suite 1702, Oklahoma City, OK 73102-6406, **Phone:** 405-426-8400, 1-800-535-2437, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.html
Oregon	**Oregon AIDS Drug Assistance Program (CAREAssist)**, **Address:** Oregon Health Authority, 800 NE Oregon Street, Suite 1105, Portland, OR 97232, **Phone:** 971-673-0144, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oregon.gov/oha/PH/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
Pennsylvania	**Pennsylvania Special Pharmaceutical Benefits Program (SPBP)**, **Address:** Department of Health, Special Pharmaceutical Benefits Program, PO Box 8808, Harrisburg, PA 17105-8808, **Phone:** 1-800-922-9384, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
Rhode Island	**Rhode Island AIDS Drug Assistance Program (ADAP)**, **Address:** Executive Office of Health & Human Services, 3 West Rd., Cranston, RI 02920, **Phone:** 401-462-3294, 401-462-3295, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx
South Carolina	**South Carolina AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, **Phone:** 1-800-856-9954, 1-800-322-2437, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program
South Dakota	**South Dakota AIDS Drug Assistance Program (ADAP)**, **Address:** South Dakota Department of Health, Ryan White Part B CARE Program, 615 E. 4th Street, Pierre, SD 57501-1700, **Phone:** 1-800-592-1861, 605-773-3737, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** doh.sd.gov/topics/diseases/infectious-diseases/disease-prevention-services/hivaids/ryan-white-part-b-program/
Tennessee	**Tennessee AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 4th Floor, Andrew Johnson Tower, 710 James Robertson Pkwy Nashville, TN 37243, **Phone:** 615-741-7500, 1-800-525-2437, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
Texas	**Texas HIV Medication Program (THMP)**, **Address:** Texas Health and Human Services, ATTN: MSJA, MC 1873, PO Box 149347, Austin, TX 78714-9347, **Phone:** 1-800-255-1090, 737-255-4300, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dshs.texas.gov/hivstd/meds

	State AIDS Drug Assistance Programs (ADAP)
Utah	**Utah AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health and Human Services, 288 N 1460 West, PO Box 142104, Salt Lake City, UT 84114-2104, **Phone:** 801-538-6197, 801-538-6191, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** epi.utah.gov/ryan-white/
Vermont	**Vermont Medication Assistance Program (VMAP)**, **Address:** Department of Health, 280 State Drive, Waterbury, VT 05671-8300 , **Phone:** 802-951-4005, 1-800-464-4343, **TTY:** 711, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** healthvermont.gov/immunizations-infectious-disease/hiv/care
Virginia	**Virginia Medication Assistance Program (VA MAP)**, **Address:** Department of Health, 109 Governor Street, Richmond, VA 23219, **Phone:** 1-855-362-0658, 1-800-533-4148, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/
Virginia	**Virginia Medication Assistance Program (VA MAP)**, **Address:** Department of Health, 109 Governor Street, Richmond, Virginia 23219, **Phone:** 1-855-362-0658, 1-800-533-4148, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/
Washington	**Washington Early Intervention Program (EIP)**, **Address:** State Department of Health, Client Services, PO Box 47841, Olympia, WA 98504-7841, **Phone:** 1-877-376-9316, 360-236-3426, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, except state holidays, **Website:** doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP
West Virginia	**West Virginia AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health & Human Resources, PO Box 6360, Wheeling, WV 26003, **Phone:** 304-232-6822, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** oeps.wv.gov/rwp/pages/default.aspx
Wisconsin	**Wisconsin HIV Drug Assistance Program (HDAP)**, **Address:** Division of Public Health, ATTN: HDAP, PO Box 2659 Madison, WI 53701-2659, **Phone:** 800-991-5532, **TTY:** 711 or 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** dhs.wisconsin.gov/hiv/hdap-clients.htm
Wyoming	**Wyoming AIDS Drug Assistance Program (ADAP)**, **Address:** Department of Health, 401 Hathaway Building, Cheyenne, WY 82002, **Phone:** 307-777-5856 (HIV Treatment Program Manager), 307-777-6563 (ADAP Coordinator), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** health.wyo.gov/publichealth/communicable-disease-unit/hiv/resources-for-patients/

	Ombudsman
Alabama	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Alabama's Long-Term Care Ombudsman**, **Address:** RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, **Phone:** 1-800-243-5463, 334-242-5743, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** alabamaageline.gov/ombudsman/
Alaska	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Alaska Long Term Care Ombudsman**, **Address:** 3745 Community Park Loop, Suite 200, Anchorage, AK 99508, **Phone:** 1-800-730-6393, 907-334-4480, **TTY:** 1-800-478-2624, 1-800-478-4970 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** akoltco.org/
Arizona	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Office of Arizona State Long-Term Care Ombudsman Program (LTCOP)**, **Address:** 1789 W. Jefferson Street, Mail Drop 6288, Phoenix, AZ 85007, **Phone:** 602-542-6454 (Ext. 9), **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** des.az.gov/LTCOP
Arkansas	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **PASSE (Provider-led Arkansas Shared Savings Entity) Ombudsman**, **Address:** Office of Substance Abuse and Mental Health Services, Office of Ombudsman PO Box 1437 Slot-S 0171 Little Rock, AR 72203-1437, **Phone:** 1-844-843-7351, **TTY:** 1-888-987-1200 option 2 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/office-of-the-passe-ombudsman/
California	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **California Department of Aging, Long-Term Ombudsman**, **Address:** 2880 Gateway Oaks Drive, Suite 200 Sacramento, CA 95833, **Phone:** 1-800-231-4024, **TTY:**1-800-735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** 24 hours a day, 7 days a week, **Website:** aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/

	Ombudsman
Colorado	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Colorado State Long-Term Care Ombudsman Program (LTCOP)**, **Address:** 1575 Sherman Street, Denver, CO 80203, **Phone:** 303-862-3524, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** COombudsman.org
Connecticut	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Connecticut Long-Term Care Ombudsman Program**, **Address:** 55 Farmington Avenue, Hartford, CT 06105-3730, **Phone:** 1-866-388-1888, 860-424-5200, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** portal.ct.gov/LTCOP
Delaware	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Delaware Long-Term Care Ombudsman Program**, **Address:** Delaware Department of Health & Social Services (DHSS), 18 N. Walnut Street, Milford, DE 19963, **Phone:** 1-855-773-1002, **TTY:**302-424-7141 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhss.delaware.gov/dhss/ltcop/
District of Columbia	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Office of the DC Long-Term Care Ombudsman**, **Address:** 601 E Street, NW, Washington DC 20049, **Phone:** 202-434-2190, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aarp.org/legal-counsel-for-elderly/what-we-do/info-2017/dc-long-term-care-ombudsman.html
Florida	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Florida's Long-Term Care Ombudsman Program**, **Address:** 4040 Esplanade Way, Suite 380, Tallahassee, FL 32399-7000, **Phone:** 1-888-831-0404, 850-414-2323, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ombudsman.elderaffairs.org/
Georgia	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Georgia Office of the State Long-Term Care Ombudsman**, **Address:** 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303, **Phone:** 1-866-552-4464, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** georgiaombudsman.org/

	Ombudsman
Hawaii	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Hawaii Long-Term Care Ombudsman (LTCO)**, **Address:** Executive Office on Aging, No. 1 Capitol District, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, **Phone:** 808-586-7268, **TTY:** 711, **Hours:** Monday–Friday 7:45 AM to 4:30 PM, **Website:** health.hawaii.gov/eoa/home/long-term-care-ombudsman-program/
Idaho	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Idaho Ombudsman Program**, **Address:** Idaho Commission on Aging, PO Box 83720, Boise, ID 83720, **Phone:** 1-877-471-2777, 208-334-3833, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.idaho.gov/stay-safe/ombudsman/
Illinois	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Illinois Long-Term Care Ombudsman Program (LTCOP)**, **Address:** Illinois Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, **Phone:** 1-800-252-8966, **TTY:** 1-888-206-1327 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** ilaging.illinois.gov/programs/ltcombudsman.html
Indiana	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Indiana Long-Term Care Ombudsman**, **Address:** 402 W. Washington Street, Room W451, PO Box 7083, MS 27, Indianapolis, IN 46207-7083, **Phone:** 1-800-622-4484, 317-232-7134, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** in.gov/ombudsman/long-term-care-ombudsman/overview/
Iowa	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Iowa Office of the State Long-Term Care Ombudsman (OSLTCO)**, **Address:** 321 E 12th St, 4th Floor, Des Moines, IA 50319, **Phone:** 1-866-236-1430, 515-725-3308, **TTY:** 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.iowa.gov/programs/programs-and-services/aging- services/ltcombudsman

	Ombudsman
Kansas	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Kansas Long-Term Care Ombudsman Program**, **Address:** 900 SW Jackson Street, Suite 1041, Topeka, KS 66612, **Phone:** 1-877-662–8362, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** ombudsman.ks.gov/
Kentucky	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Kentucky Long-Term Care Ombudsman Program**, **Address:** 3138 Custer Drive, Suite 110, Lexington, KY 40517, **Phone:** 1-800-372-2991, 859-277-9215, **TTY:** 1-800-648-6056 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 5:00 PM, **Website:** chfs.ky.gov/agencies/dail/Pages/ltcomb.aspx
Louisiana	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Long Term Care Ombudsman of Louisiana**, **Address:** Governor's Office of Elderly Affairs, 602 North 5th Street, Suite 435, Baton Rouge, LA 70802, **Phone:** 1-866-632-0922, 225-342-7100, **TTY:** 711, **Hours:** Monday–Friday 7:30 AM to 4:00 PM, **Website:** goea.la.gov/ombudsman
Maine	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Maine Long-Term Care Ombudsman Program**, **Address:** 61 Winthrop St., Augusta, ME 04330, **Phone:** 1-800-499-0229, 207-621-1079, **TTY:** 711, **Hours:** Monday–Thursday 8:00 AM to 4:30 PM, Friday 8:00 AM to 4:00 PM, **Website:** maineombudsman.org/
Maryland	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Maryland Long-Term Care Ombudsman Program**, **Address:** Maryland Department of Aging, 301 W Preston Street, Suite 1007, Baltimore, MD 21201, **Phone:** 1-800-243-3425, 410-767-1100, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** aging.maryland.gov/Pages/state-long-term-care-ombudsman.aspx
Massachusetts	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Massachusetts Long-term Care Ombudsman Program**, **Address:** Executive Office of Health and Human Services, 1 Ashburton, Room 517, Boston, MA 02108, **Phone:** 800-649-3641, **TTY:** 617-727-7750 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** mass.gov/orgs/massachusetts-long-term-care-ombudsman-program

	Ombudsman
Michigan	Ombudsman Information: The Ombudsman Program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan. **Michigan Health Link Ombudsman Program**, 15851 S. US 27, Suite 73, Lansing, MI 48906, **Phone:** 1-888-746-MHLO (**1-888-746-6456**), **TTY:** **711**, Monday–Friday 8:00 AM to 5:00 PM, **Website:** **mhlo.org/** The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Michigan Long-Term Care Ombudsman Program (MLTCOP)**, **Address:** 15851 S. US 27, Suite 73, Lansing, MI 48906, **Phone:** **1-866-485-9393**, **517-827-8040**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **mltcop.org/**
Minnesota	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Minnesota Office of Ombudsman for Long-Term Care**, **Address:** 540 Cedar Street, St. Paul, MN 55101, **Phone:** **1-800-657-3591**, **651-431-2555**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** **mn.gov/ooltc/**
Mississippi	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Mississippi Long-Term Care Ombudsman Program**, **Address:** Department of Human Services, 200 South Lamar Street, Jackson, MS 39201, **Phone:** **1-888-844-0041**, **601-359-4500**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **mdhs.ms.gov/ombudsman/**
Missouri	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Missouri Long-Term Care Ombudsman**, **Address:** 912 Wildwood Dr., PO Box 570, Jefferson City, MO 65102, **Phone:** **1-800-309-3282**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **health.mo.gov/seniors/ombudsman/**
Montana	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Montana Long Term Care Ombudsman Program**, **Address:** Senior and Long Term Care, Dept. of Public Health and Human Services, PO Box 4210, Helena, MT 59604-4210, **Phone:** **1-800-332-2272**, **1-800-551-3191**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **dphhs.mt.gov/sltc/aging/longtermcareombudsman/**

	Ombudsman
Nebraska	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Nebraska Long-Term Care Ombudsman**, **Address:** Department of Health & Human Services, 301 Centennial Mall South, Lincoln, NE 68509, **Phone:** 1-800-942-7830, 402-471-2307, **TTY:** 1-800-833-7352 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhhs.ne.gov/Pages/Aging-Ombudsman.aspx
Nevada	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Nevada State Long-Term Care Ombudsman Program (LTCOP)**, **Address:** Nevada Aging and Disability Services Division, 3416 Goni Road, Suite D-132, Carson City, NV 89706, **Phone:** 1-888-282-1155, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** adsd.nv.gov/programs/seniors/ltcombudsman/ltcombudsprog/
New Hampshire	Ombudsman Information: The Ombudsman Program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan. **New Hampshire Office of the Ombudsman**, **Address:** Office of the Ombudsman, NH Department of Health & Human Services, 105 Pleasant Street, Concord, NH 03301-3852, **Phone:** 1-800-852-3345, 603-271-6941, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** dhhs.nh.gov/about-dhhs/office-ombudsman The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **New Hampshire Office of the Long-Term Care Ombudsman**, **Address:** Office of the Commissioner, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301-3852, **Phone:** 1-800-442-5640, 603-271-4375, **TTY:** 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** dhhs.nh.gov/about-dhhs/long- term-care-ombudsman

	Ombudsman
New Jersey	Ombudsman Information: The Ombudsman Program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan. **Office of the Insurance Ombudsman**, **Address:** The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, PO Box 472, Trenton, NJ 08625-0472, **Phone:** 1-800-446-7467, 609-292-7272, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** nj.gov/dobi/ombuds.htm The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **New Jersey Office of the State Long-Term Care Ombudsman**, **Address:** NJ Long-Term Care Ombudsman, PO Box 852, Trenton, NJ 08625-0852, **Phone:** 1-877-582-6995, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** nj.gov/ooie/
New Mexico	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **New Mexico Long-Term Care Ombudsman Program**, **Address:** 2550 Cerrillos Road, Santa Fe, NM 87505, **Phone:** 1-866-451-2901, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.nm.gov/protecting-adults/ombudsman/long-term-care-ombudsman
New York	Independent Consumer Advocacy Network (ICAN) is the New York State Ombudsprogram for people with Medicaid who need long term care or behavioral health services. We assist New Yorkers with enrolling in and using managed care plans that cover long term care or behavioral health services. **Independent Consumer Advocacy Network (ICAN)**, **Address:** Community Service Society of New York, 633 Third Ave, 10th Floor, New York, NY 10017, **Phone:** 1-844-614-8800, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, **Website:** icannys.org
New York	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **New York State Long-Term Care Ombudsman Program**, **Address:** 2 Empire State Plaza, 5th Floor, Albany, NY 12223, **Phone:** 1-855-582-6769, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.ny.gov/long-term-care-ombudsman-program
North Carolina	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **North Carolina Long-Term Care Ombudsman Program**, **Address:** 2001 Mail Service Center, Raleigh, NC 27699-2101, **Phone:** 919-855-3400, 1-800-662-7030, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ncdhhs.gov/aging

	Ombudsman
North Dakota	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **North Dakota Long-Term Care Ombudsman Program**, **Address:** State Long-Term Care Ombudsman, Aging Services Division, 1237 W. Divide Ave., Ste 6, Bismarck, ND 58501, **Phone:** 1-855-462-5465 Option 3, 701-328-4617, **TTY:** 711 or 1-800-366-6888 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.nd.gov/human-services/adults-and-aging/long-term-care-ombudsman-program
Ohio	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Ohio State Long-Term Care Ombudsman**, **Address:** Ohio Department of Aging, 30 E Broad St, 22nd floor, Columbus, OH 43215, **Phone:** 1-800-282-1206, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.ohio.gov/wps/portal/gov/aging/care-and-living/get-help/get-an-advocate/long-term-care-ombudsman-1
Oklahoma	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Oklahoma Long-Term Care Ombudsman**, **Address:** PO Box 53159, Oklahoma City, OK 73152, **Phone:** 1-800-211-2116, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oklahoma.gov/oag/about/divisions/ltco.html
Oregon	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Oregon Long-Term Care Ombudsman**, **Address:** 830 D Street, NE, Salem, OR 97301, **Phone:** 1-800-522-2602, 503-378-6533, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oltco.org/programs/ltco-about-us.html
Pennsylvania	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Pennsylvania Long-Term Care Ombudsman Program**, **Address:** Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA, 17101-1919, **Phone:** 717-783-8975, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** aging.pa.gov/aging-services/Pages/Ombudsman.aspx
Rhode Island	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Rhode Island Long-Term Care Ombudsman Program**, **Address:** Office of Healthy Aging, 25 Howard Ave., Building 57, Cranston, RI 02920, **Phone:** 1-888-351-0808, 401-785-3340, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oha.ri.gov/what-we-do/protect/ombudsman-program

	Ombudsman
South Carolina	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **South Carolina Long Term Care Ombudsman Program (LTCOP)**, **Address:** South Carolina Department of Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201, **Phone:** 1-800-868-9095, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** aging.sc.gov/programs-initiatives/long-term-care-ombudsman-program
South Dakota	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **South Dakota Long-Term Care Ombudsman Program**, **Address:** Division of Long Term Services and Supports, Hillsview Plaza, 3800 E Hwy 34, c/o 500 E. Capitol Avenue, Pierre, SD 57501, **Phone:** 833-663-9673, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM (CT), **Website:** dhs.sd.gov/ltss/ombudsman.aspx
Tennessee	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Tennessee Long-Term Care Ombudsman**, **Address:** Tennessee Commission on Aging and Disability, 502 Deaderick Street, 9th Floor, Nashville, TN 37243, **Phone:** 1-877-236-0013, 612-253-5412, **TTY:** 615-532-3893 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:00 PM, **Website:** tn.gov/disability-and-aging/disability-aging-programs/long-term-care-ombudsman.html
Texas	Ombudsman Information: The Ombudsman Program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan. **Texas HHS Office of the Ombudsman, Medicaid Managed Care**, **Address:** Texas Health and Human Services Commission, Ombudsman for Managed Care, PO Box 13247, Austin, TX 78711-3247, **Phone:** 1-866-566-8989, **TTY:**711 or 1-800-735-2989 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/managed-care-help The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Texas Office of the Long-Term Care Ombudsman**, **Address:** State Long-Term Care Ombudsman, 4601 Guadalupe Street, Austin, TX 78751, **Phone:** 1-800-252-2412, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ltco.texas.gov/

	Ombudsman
Utah	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Utah Long Term-Care Ombudsman**, **Address:** State of Utah, Department of Health and Human Services, 195 N. 1950 W., Salt Lake City, Utah 84116, **Phone:** 385-222-1273, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** daas.utah.gov/long-term-care-ombudsman/
Vermont	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Vermont State Long-Term Care Ombudsman Program**, **Address:** Vermont Agency of Human Services, Dept. of Disabilities, Aging and Independent Living, HC 2 South, 280 State Drive, Waterbury, VT 05671-2070, **Phone:** 1-800-889-2047, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:00 PM, **Website:** asd.vermont.gov/services/ltc-ombudsman-program
Virginia	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Virginia Office of State Long-Term Care Ombudsman**, **Address:** Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Henrico, VA 23229-5019, **Phone:** 1-800-552-5019, 804-565-1600, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** elderrightsva.org/
Virginia	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Virginia Office of State Long-Term Care Ombudsman**, **Address:** Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Henrico, Virginia 23229-5019, **Phone:** 1-800-552-5019, 804-565-1600, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** elderrightsva.org/
Washington	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Washington State Long-Term Care Ombudsman Program**, **Address:** 1200 S. 336th Street, Federal Way, WA 98003, **Phone:** 1-800-562-6078, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 4:30 PM, **Website:** waombudsman.org/
West Virginia	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **West Virginia Long-Term Care Ombudsman Program**, **Address:** West Virginia Bureau of Senior Services, 1900 Kanawha Boulevard East, Charleston, WV 25305, **Phone:** 1-800-834-0598, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** wvseniorservices.gov/StayingSafe/LongTermCareOmbudsmanProgram/tabid/81/Default.aspx

	Ombudsman
Wisconsin	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Wisconsin Ombudsman Program**, **Address:** Wisconsin Board on Aging and Long Term Care (BOALTC), 1402 Pankratz Street #111, Madison, WI 53704, **Phone:** **1-800-815-0015**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** **longtermcare.wi.gov/Pages/Ombudsman.aspx**
Wyoming	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Wyoming Long-Term Care Ombudsman Program**, **Address:** State Long-Term Care Ombudsman, 2300 Capitol Avenue, Hathaway Building 4th Floor, Cheyenne, WY 82002, **Phone:** **307-777-2885**, **TTY:** **711**, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** **health.wyo.gov/admin/long-term-care-ombudsman-program/**



SilverScript Insurance Company
Empire Plan Medicare Rx
P.O. Box 30006, Pittsburgh, PA 15222-0330

State Health Insurance Assistance Program

State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. You will find contact information for the SHIP in your state in the Appendix of this document.

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 Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850*

Participating physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Empire Plan Medicare Rx. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-877-769-7447, 24 hours a day, 7 days a week. TTY users call 711.

NEW YORK STATE | Department of Civil Service
The Empire Plan

SilverScript Insurance Company
Empire Plan Medicare Rx
P.O. Box 30006, Pittsburgh, PA 15222-0330

Empire Plan Medicare Rx

Method	Contact Information
Call	The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and select option 4 for the Prescription Drug Program. Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week. Empire Plan Medicare Rx also has free language interpreter services available for non-English speakers.
TTY	Dial 711 (National Relay Service) and provide them The Empire Plan phone number, 1-877-769-7447, and instruct them to select option 4 for the Prescription Drug Program. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 24 hours a day, 7 days a week.
Fax	1-866-552-6205
Write	SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330
Website	empireplanrxprogram.com