Medco Medicare Prescription Plan™

Evidence of Coverage

Your Medicare prescription drug coverage as a member of Medco Medicare Prescription Plan™ for Tennessee Valley Authority (TVA)

January 1 – December 31, 2008

This booklet gives the details about your Medicare prescription drug coverage and explains how to get the prescription drugs you need. This booklet is an important legal document. Please keep it in a safe place.

Medco Medicare Prescription Plan Customer Service:

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

Calls to these numbers are free:

Phone:	**1-800-592-4520**
TTY/TDD:	**1-800-716-3231**

Hours of operation: Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.

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Section 1 Introduction

Contact Information

Telephone numbers and other information for reference

HOW TO CONTACT OUR PLAN CUSTOMER SERVICE

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

CALL	1-800-592-4520. This number is also on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.
TTY/TDD	1-800-716-3231. This number requires special telephone equipment. It is on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.
WRITE	Medco Medicare Prescription Plan Medco Health Solutions, Inc. P.O. Box 630246 Irving, TX 75063-0115
WEBSITE	**www.medco.com**

Contact information for grievances, coverage determinations, and appeals

PART D COVERAGE DETERMINATIONS

CALL	1-800-753-2851. Calls to this number are free. Our business hours are 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday.
TTY/TDD	1-800-716-3231. This number requires special telephone equipment. Calls to this number are free.
FAX	1-888-235-8551.
WRITE	Medco Medicare Prescription Plan Medco Health Solutions, Inc. Attn: Medicare Reviews P.O. Box 630367 Irving, TX 75063-0118

For information about Part D coverage determinations, see Section 8.

PART D GRIEVANCES

CALL	1-800-592-4520. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas).
TTY/TDD	1-800-716-3231. This number requires special telephone equipment. Calls to this number are free.
WRITE	Medco Medicare Prescription Plan Medco Health Solutions, Inc. Attn: Service Grievance Resolution Team P.O. Box 639405 Irving, TX 75063-9405

For information about Part D grievances, see Section 7.

PART D APPEALS

CALL	1-800-753-2851. Calls to this number are free. Our business hours are 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday.
TTY/TDD	1-800-716-3231. This number requires special telephone equipment. Calls to this number are free.
FAX	1-888-235-8551.
WRITE	Medco Medicare Prescription Plan Medco Health Solutions, Inc. Attn: Medicare Reviews P.O. Box 630367 Irving, TX 75063-0118
IN PERSON	Medco Health Solutions, Inc. Attn: Medicare Reviews 8111 Royal Ridge Parkway Irving, TX 75063

For information about Part D appeals, see Section 8.

State Health Insurance Assistance Program (SHIP) — a state program that gives free local health insurance counseling to people with Medicare

A SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage plans, Medicare prescription drug plans, Medicare cost plans, and about Medigap (Medicare supplement insurance) policies.

You can find contact information for the SHIP in your state or territory in the chart at the end of the Evidence of Coverage (EOC). You may also find the website for your local SHIP at www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites."

Quality Improvement Organization — a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 7 and 8 for more information about complaints, appeals, and grievances.

You can find contact information for the QIO in your state or territory in the chart at the end of the Evidence of Coverage.

How to contact the Medicare program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease, or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare program. CMS contracts with and regulates Medicare plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY/TDD users should call 1-877-486-2048. Customer Service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government website for Medicare information. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage plans and Medicare prescription drug plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Find Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

Other organizations (including Social Security and Medicaid)

MEDICAID AGENCY — A STATE GOVERNMENT AGENCY THAT HANDLES HEALTHCARE PROGRAMS FOR PEOPLE WITH LIMITED RESOURCES

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, refer to the list of state Medicaid programs located at the end of the Evidence of Coverage.

SOCIAL SECURITY

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

STATE PHARMACY ASSISTANCE PROGRAM (SPAP) — AN ORGANIZATION IN YOUR STATE THAT PROVIDES FINANCIAL HELP FOR PRESCRIPTION DRUGS

SPAPs are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs.

Please refer to the chart at the end of this Evidence of Coverage to locate the SPAP(s) in your state.

RAILROAD RETIREMENT BOARD

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

EMPLOYER (OR "GROUP") COVERAGE

If you or your spouse gets your benefits from your current or former employer or union, or from your spouse's current or former employer or union, call your employer's or union's benefits administrator or Customer Service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season.

Important Note: You (or your spouse's) employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Customer Service to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Welcome to Medco Medicare Prescription Plan for Tennessee Valley Authority (TVA)!

We are pleased that you've chosen our Plan.

Medco Medicare Prescription Plan is a Medicare prescription drug plan.

Thank you for your membership in **Medco Medicare Prescription Plan;** you are getting your Medicare prescription drug coverage through our Plan. **Medco Medicare Prescription Plan** is not a "Medigap" Medicare supplement insurance policy.

Throughout the remainder of this Evidence of Coverage, we refer to **Medco Medicare Prescription Plan** as "Plan" or "our Plan."

This Evidence of Coverage explains how to get your drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, Annual Notice of Change (ANOC), formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. The information in this Evidence of Coverage is in effect for the time period from January 1, 2008, through December 31, 2008.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan.

If you need this Evidence of Coverage in a different format (such as in Spanish or braille), please call us so we can send you a copy.

ELIGIBILITY REQUIREMENTS

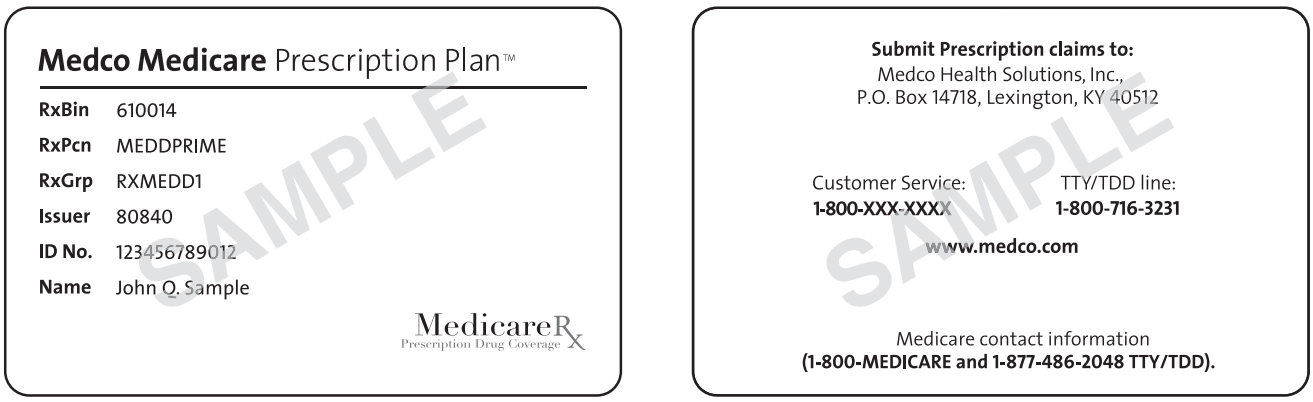
To be a member of our Plan, you must live in our service area and either be entitled to Medicare Part A or enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare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

USE YOUR PLAN MEMBERSHIP CARD, NOT YOUR RED, WHITE, AND BLUE MEDICARE CARD

Now that you are a member of our Plan, you must use our membership card for prescription drug coverage at network pharmacies. While you are a member of our Plan and using our Plan services, you *must* use your Plan membership card instead of your red, white, and blue Medicare card to get covered drugs.

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

Here is a sample card to show you what it looks like:



THE PHARMACY DIRECTORY GIVES YOU A LIST OF PLAN NETWORK PHARMACIES

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

Explanation of Benefits

WHAT IS THE EXPLANATION OF BENEFITS?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide.

WHAT INFORMATION IS INCLUDED IN THE EXPLANATION OF BENEFITS?

Your Explanation of Benefits will contain the following information:

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

WHAT SHOULD YOU DO IF YOU DON'T GET AN EXPLANATION OF BENEFITS, OR IF YOU WISH TO REQUEST ONE?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

The geographic service area for our Plan

The Plan offers Medicare prescription drug coverage in all 50 states, the District of Columbia, and Puerto Rico. If you move out of the state where you live, you must call Customer Service to update your information. If you don't, you may be disenrolled from our Plan.

Section 2 How You Get Outpatient Prescription Drugs (Part D)

IF YOU HAVE MEDICARE AND MEDICAID

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

IF YOU ARE A MEMBER OF A STATE PHARMACY ASSISTANCE PROGRAM (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your premiums, deductibles, or coinsurance/co-payments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction section for more information.

IF YOU HAVE A MEDIGAP (MEDICARE SUPPLEMENT INSURANCE) POLICY WITH PRESCRIPTION DRUG COVERAGE

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

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

IF YOU ARE A MEMBER OF AN EMPLOYER OR RETIREE GROUP

If you currently have prescription drug coverage through your employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15), your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (coverage that is at least as good as standard Medicare prescription drug coverage and expects to pay, on average, at least as much as the Medicare standard prescription drug plan expects to pay) and the options available to you. You should keep the disclosure notices that you get each year in your personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer or union.

Using network pharmacies to get your prescription drugs covered by us

WHAT ARE NETWORK PHARMACIES?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drug. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you aren't required to continue going to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must

either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

- We have a list of retail pharmacies in our network at which you can obtain an extended supply of maintenance medications. Please refer to your Pharmacy Directory or call Customer Service to locate a retail pharmacy in our network at which you can obtain an extended supply of maintenance medications.
- **What are "covered drugs"?** The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

HOW DO YOU FILL A PRESCRIPTION AT A NETWORK PHARMACY?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call the Pharmacy Services Help Desk at 1-800-922-1557 to obtain the necessary information to pay the full cost of the prescription (rather than paying just your co-payment or coinsurance). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

WHAT IF A PHARMACY IS NO LONGER A NETWORK PHARMACY?

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

HOW DO YOU FILL A PRESCRIPTION THROUGH OUR PLAN'S NETWORK MAIL-ORDER PHARMACY SERVICES?

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

Generally, it takes us 3 to 5 days to process your order and ship it to you. However, sometimes your mail order may be delayed. Make sure you have at least a 14-day supply of that medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply, and fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call the Customer Service numbers listed on the cover. We'll make sure you have your medication when you need it.

You aren't required to use our mail-order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies. Some retail pharmacies may agree to accept the mail-order co-payment or coinsurance for an extended supply of medications, for which you may not have to pay additional costs. Other retail pharmacies may provide an extended supply, but charge a higher co-payment or coinsurance than our mail-order services. Please call Customer Service or look in your Pharmacy Directory to find out which retail pharmacies offer an extended supply.

FILLING PRESCRIPTIONS OUTSIDE THE NETWORK

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have

to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay will help you qualify for catastrophic coverage.

Note: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

In a medical emergency

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling away from our Plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy service.

If you are traveling within the U.S. and need to fill a prescription because you become ill or you lose or run out of your covered medication, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the cover to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner

In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug

Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible network retail pharmacy or through our mail-order pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

HOW DO YOU SUBMIT A PAPER CLAIM?

When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Submit your claim and your receipt to the following address: Medco Medicare Prescription Plan, Medco Health Solutions, Inc., P.O. Box 14718, Lexington, KY 40512. You must submit claims no later than 3 months after the end of the benefit year for the date of purchase.

If you submit a paper claim asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 8 to learn more about requesting coverage determinations.

In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count toward qualifying you for catastrophic coverage. Additionally, if you get help from and pay co-payments under a drug manufacturer patient assistance program outside our Plan's benefit, you may submit documentation for the amount you paid and have it count toward qualifying you for catastrophic coverage. Please call Customer Service for more information.

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

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

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of-network care, and that the drugs wouldn't otherwise be covered by Medicare Part B). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage or prescription drug plan.

Long-term care pharmacies

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

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

Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies through **Medco Medicare Prescription Plan**'s pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Customer Service.

Home infusion pharmacies

Our Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under Medicare Part B,
- Our Plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.

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

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

We may cover vaccines that are preventive in nature (including the cost associated with administering the vaccine) and aren't already covered by Medicare Part B. This coverage includes the cost of vaccine administration. (Please see Section 3, "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

Section 3 Prescription Drug (Part D) Benefits

What is a formulary?

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

The drugs on the formulary are selected by our Plan with the help of a team of healthcare providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 6 for more information about the types of drugs that are not normally covered under a Medicare prescription drug plan.) In some cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 2 for more information about filling a prescription at an out-of-network pharmacy.

HOW DO YOU FIND OUT WHAT DRUGS ARE ON THE FORMULARY?

You may call Customer Service to find out if your drug is on the formulary or to request a copy of our formulary. You may also get updated information about the drugs covered by us by visiting our website, **www.medco.com**.

WHAT ARE DRUG TIERS?

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

You can ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 8 to learn more about how to request an exception.

CAN THE FORMULARY CHANGE?

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

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

If we remove drugs from the formulary, add prior authorizations, quantity limits, and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand-name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days' notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members taking the drug about the change as soon as possible.

WHAT IF YOUR DRUG ISN'T ON THE FORMULARY?

If your prescription isn't listed on the formulary, you should first contact Customer Service to be sure it isn't covered.

If Customer Service confirms that we don't cover your drug, you have three options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service or go to our formulary website, **www.medco.com**.
2. You may ask us to make an exception (which is a type of coverage determination) to cover your drug. See Section 8 to learn more about how to request an exception.
3. You can pay out of pocket for the drug and request that the Plan reimburse you by requesting an exception (which is a type of coverage determination). This doesn't obligate the Plan to reimburse you if the exception request isn't approved. If the exception isn't approved, you may appeal the Plan's denial. See Section 8 for more information on how to request an appeal.

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

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

TRANSITION POLICY

New members in our Plan may be taking drugs that aren't in our formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. See Section 8 (under "What is an exception?") to learn more about how to request an exception. Please contact Customer Service if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year, and you need help switching to an appropriate drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may cover the off-formulary drug in certain cases during the first 90 days of new membership in our Plan.

For each of the drugs that is not on our formulary or that has coverage restrictions or limits, we will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a network pharmacy. After the first 30-day supply, we will not pay for these drugs, even if the new member has been a member of the Plan less than 90 days. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term care facility (like a nursing home), we will cover a temporary 30-day transition supply (unless you have a prescription written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan, when that member is a resident of a long-term care facility. If a new member, who is a resident of a long-term care facility and has been enrolled in our Plan for more than 90 days, needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 30-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

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

Drug management programs

UTILIZATION MANAGEMENT

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

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

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

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.

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

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

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary, on our website, or by calling Customer Service. If your drug is subject to one of these additional restrictions or limits, and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 8 for more information about how to request an exception.

DRUG UTILIZATION REVIEW

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

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

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

MEDICATION THERAPY MANAGEMENT PROGRAMS

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

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

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

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

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

See your “Medicare & You” handbook for more information about drugs that are covered by Medicare Part A and Part B.

Section 4 Your Costs for Our Plan

Please Note: If you are receiving extra help with paying for your drug coverage, the amount your premium is reduced by as a member of this Plan is listed in your "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs." Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP to determine what benefits are available to you.

Paying the Plan premium for your coverage as a member of our Plan

Pay your Plan premium directly to the Plan. You may pay your premium by pension payroll deduction or bank draft. Premiums for the current month are drafted against the bank account on, or about, the 7th of each month. Drafts returned due to insufficient funds will not be resubmitted. During the next month's regular bank draft processing, the account will be drafted for both the current month's premium plus any past-due amounts. This will only be allowed four times in a 24-month period, beginning from the date of the first insufficient bank draft. After the third NSF (Not Sufficient Funds), a "Notice of Coverage Cancellation" will be issued. The notice will state that coverage will be canceled if a fourth NSF occurs.

If you have any questions about your Plan premiums or the different ways to pay them, please call the TVA Service Center at 1-888-275-8094.

Can your premiums change during the year?

Generally, your Plan premium can't change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your Plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1.

In certain cases, your Plan premium may change during the calendar year. If you aren't currently getting extra help but you qualify for it during the year, your monthly premium amount would go down. Or if you currently get extra help paying your Plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. Social Security or your State Medical Assistance Office can tell you if there is a change in your eligibility for extra help (see contact information in Section 1).

What happens if you don't pay your Plan premiums, or don't pay them on time?

Failure to pay your premiums will result in your disenrollment after a grace period of at least 30 days. You will be contacted before you are disenrolled and you will be given an opportunity to make payment to avoid disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare prescription drug plan until the next Annual Election Period, unless you qualify for a Special Enrollment Period. If you do not have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare prescription drug plan or a Medicare Advantage plan with prescription drug coverage. Should you decide later to re-enroll in our Plan, or to enroll in

another plan offered by our Plan, you will have to pay any late Plan premiums that you didn't pay from your previous enrollment in our Plan.

Paying your share of the cost when you get covered drugs

WHAT ARE "DEDUCTIBLES," "CO-PAYMENTS," AND "COINSURANCE"?

The "**deductible**" is the amount you must pay for the drugs you receive before our Plan begins to pay its share of your covered drugs. After you meet the deductible, you will reach the initial coverage period.

A "**co-payment**" is a payment you make for your share of the cost of certain covered drugs you get. A co-payment is a set amount per drug. You pay it when you get the drug. Co-payments for prescription drugs are listed later in this section.

"**Coinsurance**" is a payment you make for your share of the cost of certain covered drugs you receive. Coinsurance is a percentage of the cost of the drug. You pay your coinsurance when you get the drug. The benefits chart on the following page gives your coinsurance for covered services.

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

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see "Do you qualify for extra help?" later in this section, and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., deductible, initial coverage period, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below.

Deductible

This is the amount that must be paid each year before we begin paying for part of your drug costs. After you meet the deductible, you will reach the initial coverage period.

You will pay a yearly deductible of $50.00.

Initial Coverage Period

During the initial coverage period, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the co-payment. Your co-payment will vary depending on the drug, and where the prescription is filled.

You will pay the following for your covered prescription drugs*:

Drug Tier	Retail Pharmacy (30-day supply)	Retail Pharmacy (60-day supply)	Retail Pharmacy (90-day supply)	Medco By Mail Pharmacy (90-day supply)
Generics	$10.00 co-payment	$20.00 co-payment	$30.00 co-payment	$20.00 co-payment
Preferred Brand-name	$30.00 co-payment	$60.00 co-payment	$90.00 co-payment	$60.00 co-payment
Non-Preferred Brand-name	$50.00 co-payment	$100.00 co-payment	$150.00 co-payment	$100.00 co-payment
Specialty	$50.00 co-payment	$100.00 co-payment	$150.00 co-payment	$100.00 co-payment

* **Amounts in this chart may vary according to your individual out-of-network cost-sharing responsibility.**

Catastrophic coverage

All Medicare prescription drug plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,050 out of pocket for the year. When the total amount you have paid toward your deductible, co-payments, and the cost for covered Part D drugs reaches $4,050 you will qualify for catastrophic coverage.

During catastrophic coverage you will pay: the greater of $2.25 or 5% coinsurance for generics or drugs that are treated like generics and $5.60 for all other drugs, or 5% coinsurance. We will pay the rest.

Vaccines (including administration)

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

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts,

and then you will be reimbursed. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

- Remember you are responsible for all of the costs associated with vaccines (including their administration) during any deductible phase of your benefit.

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	**The Pharmacy (not possible in all states)**	You pay a $30.00 co-payment.
Your Doctor	**Your Doctor**	You pay up front for the entire cost of the vaccine and its administration. You are reimbursed this amount less a $30.00 co-payment, plus any difference between the amount the doctor charges and what we normally pay.* Or if your doctor agrees to submit your claim on your behalf, you pay a $30.00 co-payment, plus any difference between the amount the doctor charges and what we normally pay.*
The Pharmacy	**Your Doctor**	You pay a $30.00 co-payment at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less a $30.00 co-payment, plus any difference between what the doctor charges for administering the vaccine and what we normally pay.*

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

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

How is your out-of-pocket cost calculated?

WHAT TYPE OF PRESCRIPTION DRUG PAYMENTS COUNT TOWARD YOUR OUT-OF-POCKET COSTS?

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

- Your annual deductible;
- Your coinsurance or co-payments;
- Payments you make after the initial coverage limit.

When you have spent a total of $4,050 for these items, you will reach the catastrophic coverage level.

WHAT TYPE OF PRESCRIPTION DRUG PAYMENTS WILL NOT COUNT TOWARD YOUR OUT-OF-POCKET COSTS?

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

- Payments for drug costs made by your employer or union on your behalf;
- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan;
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage;
- Prescription drugs covered by Part A or Part B.

WHO CAN PAY FOR YOUR PRESCRIPTION DRUGS, AND HOW DO THESE PAYMENTS APPLY TO YOUR OUT-OF-POCKET COSTS?

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

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run, or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

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

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

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

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

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium, yearly deductible, and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

DO YOU QUALIFY FOR EXTRA HELP?

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

1. **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2. **You apply and qualify.** You may qualify if your yearly income in 2007 is less than $15,315 (single with no dependents) or $20,535 (married and living with your spouse with no dependents), and your resources are less than $11,710 (single) or $23,410 (married and living with your spouse). Resources include your savings and stocks, but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY/TDD users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

HOW DO COSTS CHANGE WHEN YOU QUALIFY FOR EXTRA HELP?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, yearly deductible, and prescription co-payments. The amount of extra help you get is based on your income and resources.

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

WHAT IF YOU BELIEVE YOU HAVE QUALIFIED FOR EXTRA HELP AND YOU BELIEVE THAT YOU ARE PAYING AN INCORRECT CO-PAYMENT AMOUNT?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to provide evidence of your proper co-payment level. Please call **Medco Medicare Prescription Plan** at the Customer Service numbers listed in Section 1 of this booklet. You will be asked to provide supporting documentation of your extra help status within 30 days of your initial call. Once we receive supporting documentation, your level of extra help will be updated to reflect the correct information. The acceptable forms of documentation are as follows:

- A copy of your Medicaid card, which includes your name and an eligibility date during the discrepant date;

- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A report of contact, 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 the Medicaid status during the discrepant period;
- A printout from the state electronic enrollment file showing Medicaid status during the discrepant period;
- A screen print from the state's Medicaid systems showing Medicaid status during the discrepant period;
- Other documentation provided by the state or the Medicaid Savings Program showing Medicaid status during the discrepant period; or
- An award letter from the Social Security Administration confirming Extra Help Eligibility during the discrepant period.

Please be assured that if you overpay your co-payment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Using all of your insurance coverage

If you have additional prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the drug benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our Plan if you have additional drug coverage

Important information about Medicare prescription drug coverage

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

You must tell us if you have any other prescription drug coverage besides our Plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.

- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veterans' benefits).
- Coverage you have for prescription drugs.
- "Continuation Coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

What is the Medicare prescription drug plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

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

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

- You had creditable prescription drug coverage (as good as Medicare's)
- The period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You prove that you were not informed that your prescription drug coverage was <u>not</u> creditable
- You lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan

Your late enrollment penalty may be reduced or eliminated if:

- You receive extra help in 2008 or after

Section 5 Your Rights and Responsibilities as a Member of Our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan, and we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. Or visit www.medicare.gov on the web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "Find a Medicare Publication." If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our Plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

Your right to be treated with dignity, respect, and fairness

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

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

There are Federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this Plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone to whom you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. *For example, you have the right to look at your medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies).* You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone numbers listed in Section 1 of this booklet.

The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Your right to get your prescriptions filled within a reasonable period of time

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

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage. A complaint can be called a grievance or a coverage determination, depending on the situation. See Section 8 for more information about complaints.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the numbers listed in Section 1 of this booklet. You can also get free help and information from your SHIP (the Introduction tells how to contact the SHIP in your state). You can also visit www.medicare.gov on the web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "Find a Medicare Publication." Or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

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

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

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

Your right to get information about your drug coverage and costs

This EOC tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Customer Service numbers listed in Section 1. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 8 for more information about filing an appeal. You also have the right to receive an explanation from us of any utilization management requirements, such as step therapy or prior authorization that may apply to your plan. If you have any questions, please review our website or call Customer Service.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about our Plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Service at the phone numbers listed in Section 1.

Section 6 General Exclusions

Introduction

The purpose of this section is to tell you about drugs that are "excluded," meaning they aren't normally covered by a Medicare prescription drug plan.

If you get drugs that are excluded, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the original Medicare plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 8).

Drug exclusions

A Medicare prescription drug plan can't cover a drug that would be covered under Medicare Part A or Part B. Also, while a Medicare prescription drug plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.[1] If the use is not supported by one of these reference books (known as compendia), then the drug is considered a non-Part D drug and cannot be covered by our Plan.

By law, certain types of drugs or categories of drugs are not normally covered by Medicare prescription drug plans. These drugs are not considered Part D drugs and may be referred to as "exclusions," or "non-Part D drugs." These drugs include:

Non-prescription drugs (or over-the-counter drugs)	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines
Drugs, such as *Viagra*®, *Cialis*®, *Levitra*®, and *Caverject*®, when used for the treatment of sexual or erectile dysfunction	

[1] These reference books are: (1) American Hospital Formulary Service Drug Information, (2) the DRUGDEX Information System, and (3) USPDI (or its successor).

Section 7 How to File a Grievance

What is a grievance?

A grievance is any complaint other than one that involves a request for a coverage determination or an appeal, as described in Section 8 of this booklet, because grievances do not involve problems related to approving or paying for Part D benefits.

If we will not give you the drugs you want, you must follow the rules outlined in Section 8.

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

- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from customer service.
- Problems with how long you have to wait in a network pharmacy.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- Cleanliness or condition of network pharmacies.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in more detail in Section 8.
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required timeframe (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in Section 8.

Filing a grievance with our Plan

If you have a complaint, please call the phone numbers for **Part D Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this "Medco Medicare Prescription Plan Complaints and Grievances." Medco Medicare Prescription Plan** Complaints and Grievances addresses concerns about the service you have received. For example, you may file a service grievance if you are dissatisfied with the way a staff person has handled your particular issue or with the care you received from your pharmacy. (Please note, if you have a concern about a medication that is not covered or a coverage decision, you should follow the instructions for requesting a coverage determination.) See Section 8 for additional information on coverage determinations.

If you prefer to state your grievance in writing, please send a grievance form or a letter with as much detail as possible to: Medco Medicare Prescription Plan, Medco Health Solutions, Inc., ATTN: Service Grievance Resolution Team, P.O. Box 639405, Irving, TX 75063-9405. Medco automatically approves requests by the enrollee, or an enrollee's prescribing physician, on behalf of the enrollee, either orally or in writing, for expedited processing for initial determinations and redeterminations. 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 timeframe 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.

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

You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See Section 1 for more information about how to file a quality of care complaint with the QIO.

Section 8 What to Do If You Have Complaints About Your Part D Prescription Drug Benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Customer Service at the numbers listed in Section 1 of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a Plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For more information about grievances, see Section 7.

A coverage determination is the first decision we make about covering the drug you are requesting. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you may contact us if you want to request a coverage determination. For more information about coverage determinations and exceptions, see the section "How to request a coverage determination" below.

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You cannot request an appeal if we have not issued a coverage determination. If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section "The appeals process" below.

How to request a coverage determination

WHAT IS THE PURPOSE OF THIS SECTION?

This part of Section 8 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

WHAT IS A COVERAGE DETERMINATION?

The coverage determination we make is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact us and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you may "appeal" the decision by going

on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage-determination requests:

- You ask us to pay for a prescription drug you have received. This is a request for a coverage determination about payment. You may call us at the phone numbers listed under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You may call us at the phone numbers listed under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **See "What is an exception?" below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools — such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You may call us at the phone numbers listed under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **See "What is an exception?" below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You may call us at the phone numbers listed under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **See "What is an exception?" below for more information about the exceptions process.**
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling prescriptions outside of the network" in Section 2 for a description of these circumstances. You may call us at the phone numbers listed under **Part D Coverage Determinations** in Section 1 of this booklet to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

What is an exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

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

you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the specialty drugs tier.

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

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

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

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

Who may ask for a coverage determination?

You, your prescribing physician, or someone you name may ask us for a coverage determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. This statement must be sent to us at the address listed under **Part D Coverage Determinations** in Section 1 of this booklet. To learn how to name your appointed representative, you may call Customer Service at the numbers listed in Section 1 of this booklet.

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

Asking for a "standard" or "fast" coverage determination

DO YOU HAVE A REQUEST FOR A PART D PRESCRIPTION DRUG THAT NEEDS TO BE DECIDED MORE QUICKLY THAN THE STANDARD TIMEFRAME?

A decision about whether we will give you or pay for a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is also called an "expedited coverage determination."

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

ASKING FOR A STANDARD DECISION

To ask for a standard decision, you, your doctor, or your appointed representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. Our normal business hours are from 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday. If you are requesting a decision outside of normal business hours, be sure to call (not fax) us at 1-800-753-2851 and listen to the recording for further directions.

ASKING FOR A FAST DECISION

You, your doctor, or your appointed representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. Our normal business hours are from 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday. If you are requesting a decision outside of normal business hours, be sure to call (not fax) us at 1-800-753-2851 and listen to the recording for further directions. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a coverage determination?

1. For a standard coverage determination about a Part D drug that includes a request to pay you back for a Part D drug that you already received.

   Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules — such as dosage or quantity limits or step therapy requirements) — we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

   If you have not received an answer from us within 72 hours after we receive your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a fast coverage determination about a Part D drug that you have not received.

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

If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens if we decide completely in your favor?

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

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

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

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

What happens if we decide against you?

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

The appeals process

This part of Section 8 explains what you can do if you disagree with our coverage determination.

WHAT KINDS OF DECISIONS CAN BE APPEALED?

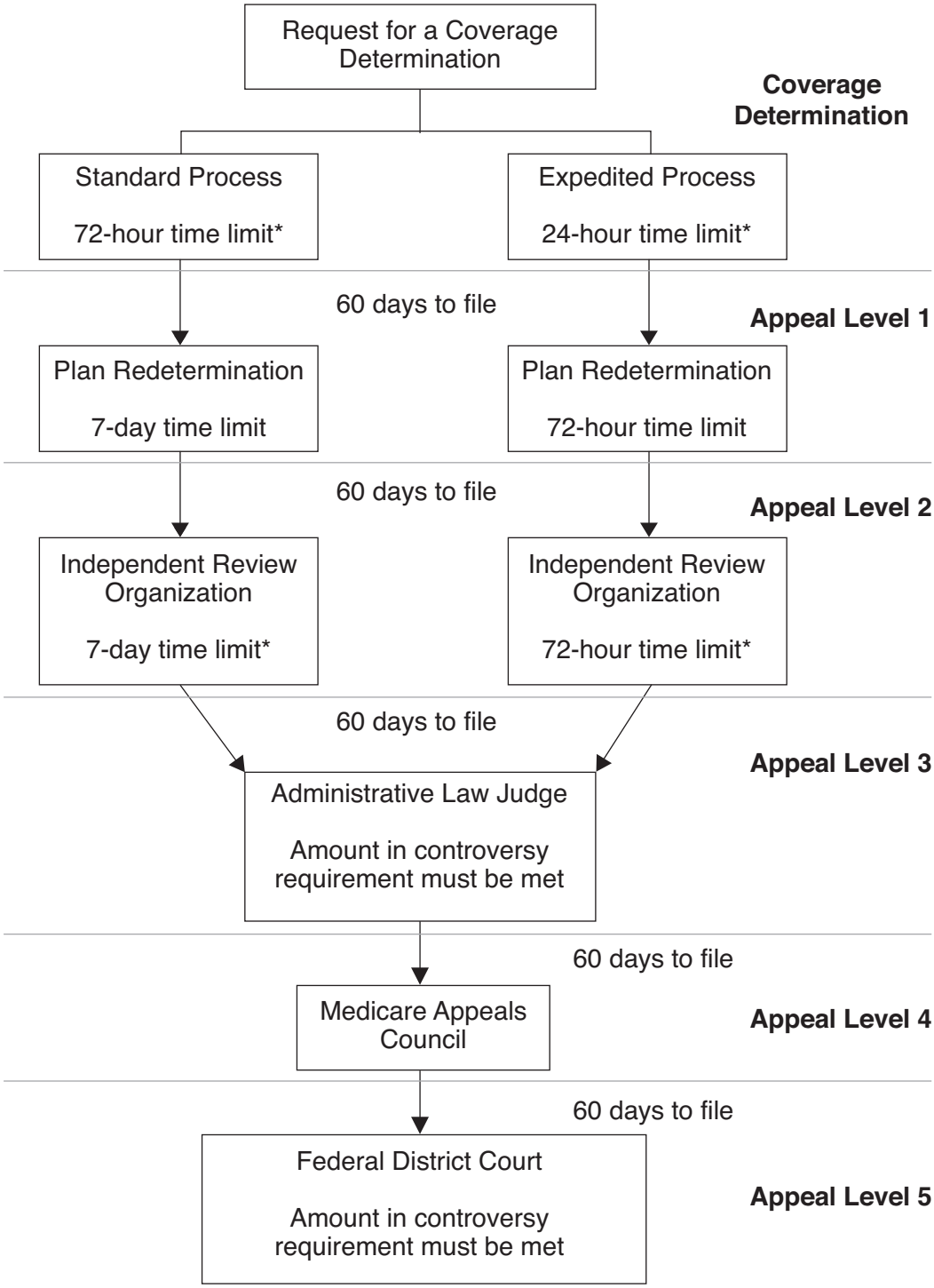
If you are not satisfied with our coverage determination decision, you may ask for an appeal called a "redetermination." You can generally appeal the following decisions:

- We do not cover a Part D drug you think you are entitled to receive,
- We do not pay you back for a Part D drug that you paid for,
- We paid you less for a Part D drug than you think we should have paid you,
- We ask you to pay a higher co-payment amount than you think you are required to pay for a Part D drug, or
- We deny your exception request.

HOW DOES THE APPEALS PROCESS WORK?

There are five levels in the appeals process. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may give you some or all of what you have asked for, or it may not give you anything you asked for. If you are unhappy with the decision, you may be able to appeal it and have someone else review your request.

The following chart summarizes the appeals process. Each appeal level is discussed in greater detail below.



* The adjudication timeframes generally begin when the request is received by the Plan sponsor. However, if the request involves an exception to the Plan's formulary, the adjudication timeframe begins when the Plan sponsor or independent review organization receives the doctor's supporting statement.

Appeal Level 1: If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

You may ask us to review our coverage determination, even if only part of our decision is not what you requested. When we receive your request to review the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

WHO MAY FILE YOUR APPEAL OF THE COVERAGE DETERMINATION?

You or your appointed representative may file a **standard appeal** request.

You, your appointed representative, or your doctor may file a **fast appeal** request.

HOW SOON MUST YOU FILE YOUR APPEAL?

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

HOW TO FILE YOUR APPEAL

1. **Asking for a standard appeal**

   To ask for a standard appeal, you or your appointed representative may send a written appeal request to the address listed under **Part D Appeals** in Section 1 of this booklet. You may also ask for a standard appeal by calling us at the phone numbers listed under **Part D Appeals** in Section 1 of this booklet.

2. **Asking for a fast appeal**

   If you are appealing a decision we made about giving you a Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in Section 1 of this booklet. Our normal business hours are from 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday. If you are requesting a decision outside of normal business hours, be sure to call (not fax) us at 1-800-753-2851 and listen to the recording for further directions. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal.

GETTING INFORMATION TO SUPPORT YOUR APPEAL

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

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in Section 1 of this booklet. You may also deliver additional information in person to the address listed under **Part D Appeals** in Section 1 of this booklet. You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone numbers or address listed under **Part D Appeals** in Section 1 of this booklet.

HOW SOON MUST WE DECIDE ON YOUR APPEAL?

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

   We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

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

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

WHAT HAPPENS IF WE DECIDE COMPLETELY IN YOUR FAVOR?

1. For a standard decision to pay you back for a Part D drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we receive your appeal request.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within seven calendar days after we receive your appeal request. We will give it to you sooner if your health requires us to.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive your appeal request. We will give it to you sooner if your health requires us to.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

WHAT INDEPENDENT REVIEW ORGANIZATION DOES THIS REVIEW?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

WHO MAY FILE YOUR APPEAL?

You or your appointed representative may file a **standard** or **fast appeal** request.

HOW SOON MUST YOU FILE YOUR APPEAL?

You must file the appeal request within 60 calendar days after the date you were notified of the decision on your first appeal. The independent review organization may give you more time if you have a good reason for missing the deadline.

HOW TO FILE YOUR APPEAL

1. **Asking for a standard appeal**

   To ask for a standard appeal, you or your appointed representative may send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us.

2. **Asking for a fast appeal**

   To ask for a fast appeal, you or your appointed representative may send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us. Remember, if your doctor provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically give you a fast appeal.

HOW SOON MUST THE INDEPENDENT REVIEW ORGANIZATION DECIDE?

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

   The independent review organization will give you its decision within seven calendar days after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the timeframe begins once the independent review organization receives your doctor's supporting statement.

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

   The independent review organization will give you its decision within 72 hours after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the timeframe begins once the independent review organization receives your doctor's supporting statement.

IF THE INDEPENDENT REVIEW ORGANIZATION DECIDES COMPLETELY IN YOUR FAVOR

The independent review organization will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already paid for and received.

   We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

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

WHO MAY FILE YOUR APPEAL?

You or your appointed representative may file an appeal request with an Administrative Law Judge.

HOW SOON MUST YOU FILE YOUR APPEAL?

The appeal request must be filed within 60 calendar days of the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

HOW TO FILE YOUR APPEAL

The request must be filed with an Administrative Law Judge in writing. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

HOW IS THE DOLLAR VALUE (THE "AMOUNT REMAINING IN CONTROVERSY") CALCULATED?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- Any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the Plan year,
- Your co-payments,
- All drug expenses after your drug costs exceed the initial coverage limit, and
- Payments for drugs made by other entities on your behalf.

YOU MAY ALSO COMBINE MULTIPLE PART D CLAIMS TO MEET THE DOLLAR VALUE IF:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

HOW SOON WILL THE JUDGE MAKE A DECISION?

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

IF THE JUDGE DECIDES IN YOUR FAVOR

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 4: If an Administrative Law Judge does not rule in your favor, your case may be reviewed by the Medicare Appeals Council

If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

WHO MAY FILE YOUR APPEAL?

You or your appointed representative may request an appeal with the Medicare Appeals Council.

HOW SOON MUST YOU FILE YOUR APPEAL?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

HOW TO FILE YOUR APPEAL

The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this appeal.

HOW SOON WILL THE COUNCIL MAKE A DECISION?

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

IF THE COUNCIL DECIDES IN YOUR FAVOR

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 5: If the Medicare Appeals Council does not rule in your favor, your case may go to a Federal Court

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

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

WHO MAY FILE YOUR APPEAL?

You or your appointed representative may request an appeal with a Federal Court.

HOW SOON MUST YOU FILE YOUR APPEAL?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

HOW TO FILE YOUR APPEAL

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review.

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

HOW SOON WILL THE JUDGE MAKE A DECISION?

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

IF THE JUDGE DECIDES IN YOUR FAVOR

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you within 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

IF THE JUDGE DECIDES AGAINST YOU

The Judge's decision is final, and you may not take the appeal any further.

Section 9 Ending Your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

In general, there are only certain times during the year when you may voluntarily end your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

TVA retirees (or eligible dependents) may disenroll from this Plan at any time. Disenrolling from this Plan will cancel prescription drug coverage as well as medical coverage in the TVA-sponsored supplement plan. If a retiree disenrolls from this Plan, coverage for all dependents will also end.

Call the TVA Service Center at 1-888-275-8094 with questions about enrolling or disenrolling.

Outside of this time period, you generally can't make other changes during the year unless you meet special exceptions, such as if you move, if you have Medicaid coverage, or if you get extra help in paying for your drugs. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each Fall. You may also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD users should call 1-877-486-2048) or visit **www.medicare.gov** to learn more about your options.

Until your membership ends, you must keep getting your Medicare services through our Plan, or you will have to pay for them yourself

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

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

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

Involuntarily ending your membership

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

- **If you move out of the service area or are away from the service area for more than 6 months in a row.** If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than 6 months in a row, you cannot remain a member of our Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do *not* stay continuously enrolled in Medicare A or B (or both).
- If you intentionally provide false information on your enrollment request about other coverage you may have.
- If you behave in a way that is disruptive. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 30-day grace period during which you may pay the Plan premiums before your membership ends.

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

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

Section 10 Legal Notices

Legal Notices

NOTICE ABOUT GOVERNING LAW

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

NOTICE ABOUT NON-DISCRIMINATION

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare prescription drug plans, like our Plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Section 11 Definitions of Some Words Used in This Booklet

Appeal — An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for a Part D drug benefit or payment for a Part D drug benefit you already received. There is a specific process that your Part D plan sponsor must use when you ask for an appeal. Section 8 explains what appeals are, including the process involved in making an appeal.

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

Catastrophic Coverage — The phase in the Part D drug benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,050 on covered drugs during the covered year. Please see Section 4 of this booklet.

Centers for Medicare & Medicaid Services (CMS) — The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination — A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

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

Creditable Prescription Drug Coverage — Prescription drug coverage (for example, from an employer or union) that is expected to pay as much as standard Medicare prescription drug coverage.

Customer Service — A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the front cover about how to contact Customer Service.

Deductible — The amount of money you must first pay for your drugs before the Plan will begin paying for your covered drugs.

Disenroll or Disenrollment — The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 9 discusses disenrollment.

Evidence of Coverage and Disclosure Information — This booklet, along with your enrollment form and any other attachments, explains your coverage, and what we must do. It also explains your rights, and what you have to do as a member of our Plan.

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

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

Generic Drug — A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Grievance — A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 7 for more information about grievances.

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

Initial Coverage Period — This is the period after you have met your deductible (if you have one) and before your total drug expenses have reached $4,050, including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty — An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able to. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

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

Medicare Advantage Plan with Prescription Drug Coverage — A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage plans also offer Medicare prescription drug coverage. A Medicare Advantage plan can be an HMO, PPO, or a Private Fee-For-Service plan.

Medicare Health Plan — A Medicare Advantage plan (such as an HMO, PPO, or Private Fee-For-Service plan) or other plan such as a Medicare cost plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plans that are offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

"Medigap" (Medicare Supplement Insurance) Policy — Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in the original Medicare plan. Medigap policies only work with the original Medicare plan.

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

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

Out-of-Network Pharmacy — A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 2.

Part D — The voluntary prescription drug benefit program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs — Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs; see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 6 for a listing of these drugs). These drugs are not considered Part D drugs.

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

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

Service Area — A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a prescription drug sponsor.

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

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

Office for Civil Rights

Region I – CT, ME, MA, NH, RI, VT

Office for Civil Rights
U.S. Department of Health
& Human Services
J. F. Kennedy Federal Building
Room 1875
Boston, MA 02203
Telephone: 1-617-565-1340
TTY/TDD: 1-617-565-1343

Region II – NJ, NY, PR, VI

Office for Civil Rights
U.S. Department of Health
& Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278
Telephone: 1-212-264-3313
TTY/TDD: 1-212-264-2355

Region III – DE, DC, MD, PA, VA, WV

Office for Civil Rights
U.S. Department of Health
& Human Services
150 S. Independence Mall West
Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Telephone: 1-215-861-4441
TTY/TDD: 1-215-861-4440

Region IV – AL, FL, GA, KY, MS, NC, SC, TN

Office for Civil Rights
U.S. Department of Health
& Human Services
Atlanta Federal Center
61 Forsyth Street, SW
Suite 3B70
Atlanta, GA 30303-8909
Telephone: 1-404-562-7886
TTY/TDD: 1-404-562-6454

Region V – IL, IN, MI, MN, OH, WI

Office for Civil Rights
U.S. Department of Health
& Human Services
233 N. Michigan Avenue
Suite 240
Chicago, IL 60601
Telephone: 1-312-886-2359
TTY/TDD: 1-312-353-5693

Region VI – AR, LA, NM, OK, TX

Office for Civil Rights
U.S. Department of Health
& Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Telephone: 1-214-767-4056
TTY/TDD: 1-214-767-8940

Region VII – IA, KS, MO, NE

Office for Civil Rights
U.S. Department of Health
& Human Services
601 East 12th Street
Room 248
Kansas City, MO 64106
Telephone: 1-816-426-7278
TTY/TDD: 1-816-426-7065

Region VIII – CO, MT, ND, SD, UT, WY

Office for Civil Rights
U.S. Department of Health
& Human Services
1961 Stout Street
Room 1426 FOB
Denver, CO 80294-2538
Telephone: 1-303-844-2024
TTY/TDD: 1-303-844-3439

Region IX – AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions

Office for Civil Rights
U.S. Department of Health
& Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Telephone: 1-415-437-8310
TTY/TDD: 1-415-437-8311

Region X – AK, ID, OR, WA

Office for Civil Rights
U.S. Department of Health
& Human Services
2201 Sixth Avenue
Mail Stop RX-11
Seattle, WA 98121
Telephone: 1-206-615-2290
TTY/TDD: 1-206-615-2296

Appendix I State Pharmacy Assistance Programs (SPAPs)

Connecticut	**Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (CONNPACE)** **Connecticut Department of Social Services** P.O. Box 5011 Hartford, CT 06102	toll-free: 1-800-423-5026 *(in-state calls only)* local: 1-860-409-4555
Delaware	**Delaware Prescription Assistance Program** **The Division of Social Services** P.O. Box 950 1901 N. DuPont Highway, Lewis Building New Castle, DE 19720	toll-free: 1-800-996-9969 local: 1-302-255-9668
Florida	**Florida Comprehensive Health Association** 820 E. Park Avenue, Suite D-200 Tallahassee, FL 32301 *(Closed to new enrollees since 1991)*	local: 1-850-309-1200
Illinois	**Illinois Cares RX** **SeniorCare Illinois Department on Aging** P.O. Box 19022 Springfield, IL 62794	toll-free: 1-800-252-8966 TTY/TDD: 1-888-206-1327
Indiana	**HoosierRx** P.O. Box 6224 Indianapolis, IN 46206-6224	toll-free: 1-866-267-4679 local: 1-317-234-1381
Maine	**Maine Low Cost Drugs for the Elderly or Disabled (DEL) Program** **Office of MaineCare Services** 126 Sewan Street Augusta, ME 04330	toll-free: 1-866-796-2463 TTY/TDD: 1-800-423-4331
Maryland	**Maryland Medicaid Pharmacy Program (MPAP)** 201 W. Preston Street, Room 408/409 Baltimore, MD 21201	toll-free: 1-800-492-5231 local: 1-410-767-1755
Massachusetts	**Prescription Advantage Plan** P.O. Box 15153 Worcester, MA 01615-0153	toll-free: 1-800-243-4636 TTY/TDD: 1-977-610-0241

Appendix I State Pharmacy Assistance Programs (SPAPs)

Missouri	**Missouri Rx Plan** P.O. Box 6500 205 Jefferson Street, 14th Floor Jefferson City, MO 65102-6500	toll-free: 1-800-375-1406
Montana	**Big Sky Rx Program** 111 North Sander Street P.O. Box 202915 Helena, MT 59620-2915	toll-free: 1-866-369-1233 *(in-state calls only)* local: 1-406-444-4077
Nevada	**Nevada Senior Rx** **Department of Health & Human Resources** 4126 Technology Way, Suite 101 Carson City, NV 89706-2009	toll-free: 1-866-303-6323 local: 1-775-687-7555
	Nevada Disability Rx **Department of Human Resources** 4126 Technology Way, Suite 101 Carson City, NV 89706-2009	toll-free: 1-866-303-6323 local: 1-775-687-7555
New Jersey	**Prescription Assistance to the Aged and Disabled Program (PAAD)** **Division of Senior Benefits and Utilization Management** **New Jersey Department of Health & Senior Services** P.O. Box 715 Trenton, NJ 08625-0715	toll-free: 1-800-792-9745 local: 1-609-588-7180
	Senior Gold **Division of Senior Benefits and Utilization Management** **New Jersey Department of Health & Senior Services** P.O. Box 724 Trenton, NJ 08625	toll-free: 1-800-792-9745 local: 1-609-588-7048
New York	**Elderly Pharmaceutical Insurance Coverage (EPIC)** P.O. Box 15018 Albany, NY 12212-5018	toll-free: 1-800-332-3742 TTY/TDD: 1-800-290-9138
Pennsylvania	**Pharmaceutical Assistance Contract for the Elderly (PACE)** **1st Health Services** 4000 Crums Mill Road, Suite 301 Harrisburg, PA 17112	toll-free: 1-800-225-7223

Appendix I State Pharmacy Assistance Programs (SPAPs)

Rhode Island	**Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)** **John O. Pastore Center** Benjamin Rush, Building 55 35 Howard Avenue Cranston, RI 02920	local: 1-401-462-3000 TTY/TDD: 1-401-462-0740
South Carolina	**Gap Assistance Program for Seniors (GAPS)** **Department of Health and Human Services** P.O. Box 8206 Columbia, SC 29202	toll-free: 1-888-549-0820
Texas	**Texas Kidney Health Care Program (KHC)** **Texas Department of State Health Services** 1100 West 49th Street Austin, TX 78756	toll-free: 1-800-222-3986 local: 1-512-458-7150
Vermont	**VPharm** **Vermont Agency of Human Services** **Department of Prevention, Assistance, Transition, and Health Access (PATH)** 312 Hurricane Lane, Suite 201 Williston, VT 05495	toll-free: 1-800-250-8427 TTY/TDD: 1-888-834-7898
	Vermont Health Access Plan (VHAP-Pharmacy) 103 South Main Street Waterbury, VT 05676	toll-free: 1-800-250-8427
	VSCRIPT 103 South Main Street Waterbury, VT 05676	toll-free: 1-800-250-8427
	VSCRIPT Expanded 103 South Main Street Waterbury, VT 05676	toll-free: 1-800-250-8427
Washington	**Washington State Health Insurance** **State Pharmacy Assistance Program** **State Department of Social and Health Services** **Customer Service Center** P.O. Box 1090 Great Bend, KS 67530 *(Enrollment is closed.)*	toll-free: 1-800-877-5187

Appendix I State Pharmacy Assistance Programs (SPAPs)

Wisconsin	**Wisconsin SeniorCare** P.O. Box 6710 Madison, WI 53716	toll-free: 1-800-657-2038

Appendix II State Health Insurance Assistance Programs (SHIPs)

Alabama	**Alabama Department of Senior Services** P.O. Box 301851 770 Washington Avenue, RSA Plaza Suite 470 Montgomery, AL 36130-1851	toll-free: 1-800-243-5463 local: 1-334-242-5743 TTY/TDD: 1-334-242-0995
Alaska	**Alaska Medicare Information** **Division of Senior and Disabilities Services** **Department of Health and Senior Services** 3601 C Street, Suite 310 Anchorage, AK 99503-5209	toll-free: 1-800-478-6065 *(in-state calls only)* local: 1-907-269-3680 TTY/TDD: 1-907-269-3691
Arizona	**Arizona State Health Insurance** **Assistance Program** **Arizona Aging and Adult Administration** 1789 West Jefferson, Suite #950A Phoenix, AZ 85007	toll-free: 1-800-432-4040 TTY/TDD: 1-602-542-6366
Arkansas	**State Health Insurance Information Program** **Arkansas State Insurance Department** 1200 West Third Street Little Rock, AR 72201-1904	toll-free: 1-800-224-6330 local: 1-501-371-2782
California	**Health Insurance Counseling and** **Advocacy Program (HICAP)** 5380 Elvas Avenue, Suite 104 Sacramento, CA 95814	toll-free: 1-800-434-0222 *(in-state calls only)* local: 1-916-231-5110
Colorado	**Colorado State Health Insurance** **Assistance Program** 1560 Broadway, Suite 850 Denver, CO 80202	toll-free: 1-888-696-7213 local: 1-800-544-9181 TTY/TDD: 1-303-894-7880
Connecticut	**CHOICES** **Connecticut Department of Social Services** 25 Sigourney Street, 10th Floor Hartford, CT 06106	toll-free: 1-866-218-6631 *(in-state calls only)* local: 1-860-424-5274
Delaware	**ELDERinfo** **Delaware Insurance Department** Rodney Building 841 Silverlake Boulevard Dover, DE 19904	toll-free: 1-800-336-9500 *(in-state calls only)* local: 1-302-674-7364

Appendix II State Health Insurance Assistance Programs (SHIPs)

District of Columbia	**Washington, D.C. Health Insurance Counseling Project (HICAP)** 2136 Pennsylvania Avenue, NW Washington, D.C. 20052	local: 1-202-739-0668 TTY/TDD: 1-202-973-1079
Florida	**Florida Department of Elder Affairs** 4040 Esplanade Way, Suite 2805 Tallahassee, FL 32399-7000	toll-free: 1-800-963-5337 local: 1-850-414-2060 TTY/TDD: 1-850-414-2001
Georgia	**GeorgiaCares** **Division of Aging Services** 2 Peachtree Street, NE, Suite 9-230 Atlanta, GA 30303	toll-free: 1-800-669-8387 local: 1-404-657-5334
Hawaii	**SAGE Plus** 250 South Hotel Street, 4th Floor Honolulu, HI 96813-2831	toll-free: 1-888-875-9229 local: 1-808-586-7299
Idaho	**Senior Health Insurance Benefits Advisors of Idaho (SHIBA)** 700 West State Street, 3rd Floor Boise, ID 83720-0043	toll-free: 1-800-247-4422 *(in-state calls only)* local: 1-208-334-4350
Illinois	**Senior Health Insurance Information Program of Illinois (SHIIP)** 320 W. Washington Street Springfield, IL 62767-0001	toll-free: 1-800-548-9034 *(in-state calls only)* local: 1-217-785-9021 TTY/TDD: 1-217-524-4872
Indiana	**Indiana Senior Health Insurance Information Program (SHIIP)** 311 W. Washington Street, Suite #300 Indianapolis, IN 46204-2787	toll-free: 1-800-452-4800 local: 1-317-233-3551
Iowa	**Senior Health Insurance Information Program of Iowa (SHIIP)** 330 Maple Street Des Moines, IA 50319-0065	toll-free: 1-800-351-4664 local: 1-515-281-5705
Kansas	**Senior Health Insurance Counseling for Kansas (SHICK)** New England Building 503 S. Kansas Avenue Topeka, KS 66603-3403	toll-free: 1-800-860-5260 local: 1-316-337-7386

Appendix II State Health Insurance Assistance Programs (SHIPs)

Kentucky	**State Health Insurance Program** **Kentucky Cabinet for Health Services** 275 E. Main Street, 5C-D Frankfort, KY 40621	toll-free: 1-877-293-7447 local: 1-502-564-6930
Louisiana	**Louisiana Senior Health Insurance Information Program** 1702 North Third Street P.O. Box 94214 Baton Rouge, LA 70804-9214	toll-free: 1-800-259-5301 *(in-state calls only)* local: 1-225-342-5301
Maine	**Maine Health Insurance Counseling Program** 442 Civic Center Drive State House Station, Room 411 Augusta, ME 04333-0011	toll-free: 1-877-353-3771 *(in-state calls only)* local: 1-207-621-0087
Maryland	**Maryland Senior Health Insurance Assistance Program** 301 West Preston Street Baltimore, MD 21201	toll-free: 1-800-243-3425 *(in-state calls only)* local: 1-410-767-1100
Massachusetts	**Serving Health Information Needs of Elders (SHINE)** 1 Ashburton Place, 5th Floor Boston, MA 02108	toll-free: 1-800-243-4636 local: 1-617-222-7435
Michigan	**Medicare/Medicaid Assistance Program of Michigan (MMAP)** 6105 W. St. Joseph Lansing, MI 48917-4850	toll-free: 1-800-803-7174 local: 1-517-886-1242
Minnesota	**Minnesota SHIP/Senior LinkAge Line** 540 Cedar Street P.O. Box 64976 St. Paul, MN 55164-0976	toll-free: 1-800-333-2433
Mississippi	**Mississippi Insurance Counseling and Assistance Program (MICAP)** 750 North State Street Jackson, MS 39202	toll-free: 1-800-948-3090 local: 1-601-359-4929
Missouri	**CLAIM Program of Missouri** 3425 Constitution Court, Suite E Jefferson City, MO 65109	toll-free: 1-800-390-3330 local: 1-573-817-8320

Appendix II State Health Insurance Assistance Programs (SHIPs)

Montana	**State Health Insurance Counseling Program (SHIC)** 111 North Sanders Street, Room 210 Helena, MT 59604	toll-free: 1-800-551-3191 *(in-state calls only)* local: 1-406-444-7870
Nebraska	**Nebraska State Health Insurance Information Counseling and Assistance Program (NICA)** Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690	toll-free: 1-800-234-7119 local: 1-402-471-2201
Nevada	**State Health Insurance Advisory Program of Nevada** 3100 W. Sahara Avenue, Suite 103 Las Vegas, NV 89102	toll-free: 1-800-307-4444 local: 1-702-486-3478
New Hampshire	**HICEAS** **Health Insurance Counseling, Education, Assistance Service** 192 Pleasant Street State Office Concord, NH 03301	toll-free: 1-800-852-3388 *(in-state calls only)* local: 1-603-225-9000
New Jersey	**Senior Health Insurance Assistance Program** **New Jersey Department of Health and Senior Services** P.O. Box 807 Trenton, NJ 08625-0807	toll-free: 1-877-222-3737 *(in-state calls only)* local: 1-609-943-3437
New Mexico	**Benefits Counseling Program** **New Mexico State Agency on Aging** 2550 Cerrillos Road Santa Fe, NM 87505	toll-free: 1-800-432-2080 *(in-state calls only)* local: 1-505-476-4799
New York	**Health Insurance Information and Counseling Assistance Program (HIICAP)** 2 Empire State Plaza Agency Building #2 Albany, NY 12223-1251	toll-free: 1-800-701-0501 local: 1-212-341-3978
North Carolina	**North Carolina Senior Health Insurance Information Program (SHIIP)** 111 Seaboard Avenue Raleigh, NC 27604	toll-free: 1-800-443-9354

Appendix II State Health Insurance Assistance Programs (SHIPs)

North Dakota	**Senior Health Insurance Counseling** 600 East Boulevard, Department 401 Bismarck, ND 58505	toll-free: 1-800-247-0560 local: 1-701-328-2440
Ohio	**Senior Health Insurance Information Program of Ohio (SHIP)** 2100 Stella Court Columbus, OH 43215-1067	toll-free: 1-800-686-1578 local: 1-614-644-3458 TTY/TDD: 1-614-644-3745
Oklahoma	**Oklahoma Senior Health Insurance Counseling Program (SHICP)** **P.O. Box 53408** 2401 N.W. 23rd Street, Suite 28 Oklahoma City, OK 73107	toll-free: 1-800-763-2828 *(in-state calls only)* local: 1-405-521-6628
Oregon	**Oregon Senior Health Insurance Benefits Assistance (SHIBA)** 350 Winter Street, Northeast, Room 440 Salem, OR 97301-3883	toll-free: 1-800-722-4134 *(in-state calls only)* local: 1-503-378-2014 TTY/TDD: 1-503-947-7280
Pennsylvania	**APPRISE** 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919	toll-free: 1-800-783-7067 local: 1-717-783-8975
Puerto Rico	**Puerto Rico Governor's Office of Elderly Affairs** Cobias Plaza Building UM Level Step 23 Ponce de Leon, PR 00902	toll-free: 1-877-725-4300 local: 1-787-721-6121
Rhode Island	**Rhode Island Senior Health Insurance Program (SHIP)** 160 Pine Street Providence, RI 02903-3708	local: 1-401-462-3000 TTY/TDD: 1-401-462-0740
South Carolina	**Insurance Counseling Assistance & Referrals for Elders (I-CARE)** 1801 Main Street Columbia, SC 29202-8206	toll-free: 1-800-868-9095 local: 1-803-734-9900
South Dakota	**Senior Health Information and Insurance Education (SHINE)** 2300 West 46th Street Sioux Falls, SD 57104	toll-free: 1-800-536-8197 local: 1-605-773-3656 TTY/TDD: 1-605-367-5760

Appendix II State Health Insurance Assistance Programs (SHIPs)

Tennessee	**Tennessee Commission on Aging and Disability** Andrew Jackson Building, 8th Floor 500 Deaderick Street Nashville, TN 37243-0860	toll-free: 1-877-801-0044 local: 1-615-532-3893
Texas	**Health Insurance Information, Counseling, and Advocacy Program (HICAP)** 4900 N. Lamar P.O. Box 12786 Austin, TX 78751	toll-free: 1-800-252-9240
Utah	**Health Insurance Information Program (HIIP)** **Aging and Adult Services of Utah** 120 North 200 West Street P.O. Box 45500 Salt Lake City, UT 84103	toll-free: 1-800-541-7735 *(in-state calls only)* local: 1-801-538-3910
Vermont	**(SHIP) Area Agency on Aging of Vermont** 1161 Portland Street St. Johnsbury, VT 05819	toll-free: 1-800-642-5119 *(in-state calls only)* local: 1-802-751-0428
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)** 1600 Forest Avenue, Suite 102 Richmond, VA 23229	toll-free: 1-800-552-3402 local: 1-804-662-9333
Washington	**Statewide Health Insurance Benefits Advisors of Washington** 810 Third Avenue, Suite 650 Seattle, WA 98104-1615	toll-free: 1-800-397-4422 TTY/TDD: 1-360-586-0241
West Virginia	**Bureau of Senior Services of West Virginia** 1900 Kanawha Boulevard, East Building #10 Charleston, WV 25305-0160	toll-free: 1-877-987-4463 local: 1-304-558-3317
Wisconsin	**Elderly Benefits Specialists** 1 West Wilson Street, Room 450 P.O. Box 7850 Madison, WI 53703-2118	toll-free: 1-800-242-1060 local: 1-608-267-3201
Wyoming	**Wyoming State Health Assistance Program (WYSIHP)** P.O. Box 30 Riverton, WY 82501	toll-free: 1-800-856-4398 local: 1-307-777-7401

Appendix III State Medicaid Offices

Alabama	**Alabama Medicaid Agency** 501 Dexter Avenue P.O. Box 5624 Montgomery, AL 36103-5624	local: 1-334-242-5000 toll-free: 1-800-362-1504
Alaska	**Alaska Department of Health and Social Services** 350 Main Street, Room 229 P.O. Box 110601 Juneau, AK 99811-0601	local: 1-907-465-1617 TTY/TDD: 1-907-586-4265
Arizona	**Arizona Health Care Cost Containment System** 801 E. Jefferson Phoenix, AZ 85034	local: 1-602-417-4711 toll-free: 1-800-654-8713 *(in-state calls only)* toll-free: 1-800-523-0231 *(out of state)* TTY/TDD: 1-602-417-4191
Arkansas	**Department of Human Services of Arkansas** P.O. Box 1437, Slot S401 700 Main Street Little Rock, AR 72203	local: 1-501-682-8740 toll-free: 1-800-482-5431 TTY/TDD: 1-501-682-6789
California	**California Department of Health Services** 1501 Capitol Avenue, 6th Floor Sacramento, CA 95814	local: 1-916-440-7400
Colorado	**Department of Health Care Policy and Financing of Colorado** 1570 Grant Street Denver, CO 80203-1818	local: 1-303-866-5929 toll-free: 1-800-221-3943 TTY/TDD: 1-303-866-3883
Connecticut	**Department of Social Services of Connecticut** 25 Sigourney Street Hartford, CT 06106-5033	local: 1-860-424-5116 toll-free: 1-800-842-1508 *(in-state calls only)*
District of Columbia	**Department of Health** 825 North Capitol Street, NE, Suite 5135 Washington, DC 20002	local: 1-202-442-5988 toll-free: 1-888-557-1116 *(in-state calls only)* TTY/TDD: 1-202-639-4041

Appendix III State Medicaid Offices

Delaware	**Delaware Health and Social Services** P.O. Box 906, Lewis Building New Castle, DE 19720	local: 1-302-255-9627 toll-free: 1-800-372-2022
Florida	**Agency for Health Care Administration of Florida** 2727 Mahan Drive, Mail Stop 8 Tallahassee, FL 32308	local: 1-850-488-3560 toll-free: 1-866-762-2237 *(in-state calls only)*
Georgia	**Georgia Department of Community Health** 2 Peachtree Street, Suite 3733 Atlanta, GA 30303	local: 1-404-657-1502 toll-free: 1-866-322-4260
Hawaii	**Department of Human Services of Hawaii** P.O. Box 700190 Kapolei, HI 96709-0190	local: 1-808-692-8050 TTY/TDD: 1-808-692-7182
Idaho	**Idaho Department of Health and Welfare** 3232 Elder Street Boise, ID 83705	local: 1-208-334-5747 toll-free: 1-877-200-5441 TTY/TDD: 1-208-332-7205
Illinois	**Illinois Department of Public Aid** 201 South Grand Avenue East, 3rd Floor Springfield, IL 62763-0001	local: 1-217-782-2570 toll-free: 1-866-468-7543
Indiana	**Family and Social Services Administration of Indiana** 402 W. Washington Street, Room W382 Indianapolis, IN 46204-2739	local: 1-317-233-4690 toll-free: 1-800-889-9949
Iowa	**Department of Human Services of Iowa** 100 Army Post Road Des Moines, IA 50315	local: 1-515-725-1123 toll-free: 1-800-338-8366
Kansas	**Kansas Health Policy Authority** 900 SW Jackson Avenue, Suite 900-N Topeka, KS 66612	local: 1-785-368-8162 toll-free: 1-800-766-9012 TTY/TDD: 1-785-296-1491
Kentucky	**Department of Medicaid Services** 275 East Main Street, 6 West A Frankfort, KY 40621	local: 1-502-564-4321 toll-free: 1-800-635-2570

Appendix III State Medicaid Offices

Louisiana	**Louisiana Department of Health and Hospitals** 6268 North 4th Street P.O. Box 91030 Baton Rouge, LA 70821-9030	local: 1-225-342-3891 toll-free: 1-888-342-6207 *(in-state calls only)* TTY/TDD: 1-225-216-7387
Maine	**Maine Department of Health and Human Services** #11 State House Station 442 Civic Center Drive Augusta, ME 04333-0011	local: 1-207-287-2093 toll-free: 1-800-977-6740 TTY/TDD: 1-207-287-1828
Maryland	**Department of Health and Mental Hygiene** 201 West Preston Street, Room 525 Baltimore, MD 21201	local: 1-410-767-4073 toll-free: 1-800-492-5231
Massachusetts	**Office of Medicaid** 1 Ashburton Place, 11th Floor, Room 1109 Boston, MA 02108	local: 1-617-573-1770 toll-free: 1-800-325-5231
Michigan	**Michigan Department of Community Health** Capitol Commons Center, 7th Floor 400 S. Pine Street Lansing, MI 48909	local: 1-517-241-7882 toll-free: 1-800-642-3195 *(in-state calls only)* TTY/TDD: 1-517-373-3573
Minnesota	**Department of Human Services of Minnesota** P.O. Box 64998 St. Paul, MN 55164-0098	local: 1-651-431-2914 toll-free: 1-800-657-3739 TTY/TDD: 1-651-296-5705
Mississippi	**Division of Medicaid** 239 North Lamar Street Suite 801 Robert E. Lee Building Jackson, MS 39201-1325	local: 1-601-359-9562 toll-free: 1-800-421-2408 TTY/TDD: 1-800-855-1000
Missouri	**Department of Social Services of Missouri** 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65109	local: 1-573-751-6922 toll-free: 1-800-392-2161 *(in-state calls only)*

Appendix III State Medicaid Offices

Montana	**Montana Department of Public Health & Human Services** P.O. Box 4210 111 N. Sanders Helena, MT 59604	local: 1-406-444-4084 toll-free: 1-800-362-8312 *(in-state calls only)*
Nebraska	**Nebraska Department of Health and Human Services System—Medicaid Division** P.O. Box 95044 301 Centennial Mall South, 3rd Floor Lincoln, NE 68509-5044	local: 1-402-471-3121 toll-free: 1-800-430-3244 TTY/TDD: 1-402-471-9570
New Hampshire	**New Hampshire Department of Health and Human Services** 129 Pleasant Street Concord, NH 03301-6521	local: 1-603-271-5254 toll-free: 1-800-852-3345 *(in-state calls only)*
New Jersey	**Department of Human Services of New Jersey** 7 Quakerbridge Plaza P.O. Box 712 Trenton, NJ 08625-0712	local: 1-609-588-2600 toll-free: 1-800-356-1561 *(in-state calls only)*
New Mexico	**Department of Human Services of New Mexico** P.O. Box 2348 Sante Fe, NM 87504-2348	local: 1-505-827-3106 toll-free: 1-888-997-2583 TTY/TDD: 1-505-827-3184
Nevada	**Nevada Department of Human Resources, Aging Division** 1100 East William Street, Suite 101 Carson City, NV 89710	local: 1-775-684-3677 toll-free: 1-800-992-0900 *(in-state calls only)*
New York	**New York State Department of Health Office of Health Insurance Programs** Governor Nelson A. Rockefeller Empire State Plaza Room 1466, Corning Tower Building Albany, NY 12237	local: 1-518-474-3018 toll-free: 1-800-541-2831
North Carolina	**North Carolina Department of Health and Human Services Division of Medical Assistance** 2517 Mail Service Center 1985 Umstead Drive Raleigh, NC 27699-2517	local: 1-919-855-4100 toll-free: 1-800-662-7030

Appendix III State Medicaid Offices

North Dakota	**Department of Human Services of North Dakota - Medical Services** 600 E. Boulevard Avenue, Department 325 Bismarck, ND 58505-0250	local: 1-701-328-1603 toll-free: 1-800-755-2604 TTY/TDD: 1-701-328-8950
Ohio	**Department of Job and Family Services of Ohio - Ohio Health Plans** 30 East Broad Street, 31st Floor Columbus, OH 43215-3414	local: 1-614-466-4443 toll-free: 1-800-324-8680
Oklahoma	**Health Care Authority of Oklahoma** 4545 N. Lincoln Boulevard Suite 124 Oklahoma City, OK 73105	local: 1-405-522-7417 toll-free: 1-800-522-0310 TTY/TDD: 1-405-522-7179
Oregon	**Office of Medical Assistance Programs** 500 NE Summer Street, 3rd Floor Salem, OR 97301-1079	local: 1-503-945-5772 toll-free: 1-800-527-5772 *(in-state calls only)*
Pennsylvania	**Department of Public Welfare of Pennsylvania** Health and Welfare Building, Room 515 Commonwealth Avenue & Foster Street P.O. Box 2675 Harrisburg, PA 17105	local: 1-717-787-1870 toll-free: 1-800-692-7462 TTY/TDD: 1-717-705-7103
Puerto Rico	**Medicaid Office of Puerto Rico and Virgin Islands** Calle 6 Mis, Brasilia Vega Baja, PR 00693	local: 1-787-250-0453 toll-free: 1-877-725-4300
Rhode Island	**Department of Human Services of Rhode Island** Louis Pasteur Building 600 New London Avenue Cranston, RI 02920	local: 1-401-462-3575 toll-free: 1-800-984-8989 *(in-state calls only)* TTY/TDD: 1-401-462-3363
South Carolina	**South Carolina Department of Health and Human Services** P.O. Box 8206 1801 Main Street Columbia, SC 29202-8206	local: 1-803-898-2504

Appendix III State Medicaid Offices

South Dakota	**Department of Social Services of South Dakota** 700 Governors Drive Richard F. Kneip Building Pierre, SD 57501-2291	local: 1-605-773-3495 toll-free: 1-800-452-7691 *(in-state calls only)*
Tennessee	**Bureau of TennCare** 301 Great Circle Road Nashville, TN 37243	local: 1-615-507-6000 toll-free: 1-866-311-4287
Texas	**Health and Human Services Commission of Texas** 1100 West 49th Street Mail Code H100 P.O. Box 85200 Austin, TX 78708	local: 1-512-491-1867 toll-free: 1-877-541-7905 TTY/TDD: 1-512-407-3250
Utah	**Utah Department of Health** P.O. Box 141000 Salt Lake City, UT 84114-1000	local: 1-801-538-6111 toll-free: 1-800-662-9651
Virginia	**Department of Medical Assistance Services** 600 East Broad Street Suite 1300 Richmond, VA 23219	local: 1-804-786-8099 toll-free: 1-800-552-8627 *(in-state calls only)*
Vermont	**Agency of Human Services of Vermont** 312 Hurricane Lane, Suite 201 Williston, VT 05495	local: 1-802-879-5901 toll-free: 1-800-250-8427 *(in-state calls only)* TTY/TDD: 1-802-241-1282
Washington	**Department of Social and Health Services of Washington** P.O. Box 45507 Olympia, WA 98504-5507	local: 1-360-725-1867 toll-free: 1-800-562-3022 *(in-state calls only)*
West Virginia	**West Virginia Department of Health & Human Resources** 350 Capitol Street, Room 251 Charleston, WV 25301-3706	local: 1-304-558-1700

Appendix III State Medicaid Offices

Wisconsin	**Wisconsin Department of Health and Family Services** 1 West Wilson Street, Room 350 P.O. Box 309 Madison, WI 53701-0309	local: 1-608-266-8922 toll-free: 1-800-362-3002 TTY/TDD: 1-608-267-7371
Wyoming	**Wyoming Department of Health** Quest Building 6101 Yellowstone Road Suite 210 Cheyenne, WY 82009	local: 1-307-777-7531 TTY/TDD: 1-307-777-5648

Appendix IV Quality Improvement Organizations (QIOs)

Alabama	**Alabama Quality Assurance Foundation** 2 Perimeter Park South, Suite 200 W Birmingham, AL 35243	local: 1-205-970-1600 toll-free: 1-800-760-4550
Alaska	**Mountain-Pacific Quality Health** 4241 B Street, Suite 303 Anchorage, AK 99503	local: 1-907-561-3202 toll-free: 1-800-524-6550
Arizona	**Health Services Advisory Group** 1600 East Northern Avenue, Suite 100 Phoenix, AZ 85020	local: 1-602-264-6382 toll-free: 1-800-359-9909
Arkansas	**Arkansas Foundation for Medical Care** 2201 Brooken Hill Drive Fort Smith, AR 72908	local: 1-479-649-8501 toll-free: 1-800-272-5528
California	**Lumetra** One Sansome Street San Francisco, CA 94104	local: 1-415-677-2000 toll-free: 1-800-841-1602
Colorado	**Colorado Foundation for Medical Care** 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708	local: 1-303-695-3300 toll-free: 1-800-950-8250 TTY/TDD: 1-303-695-3314
Connecticut	**Qualidigm** 100 Roscommon Drive Middletown, CT 06457	local: 1-860-632-2008 toll-free: 1-800-553-7590
Delaware	**Quality Insights of Delaware** Plaza III, 1847 Marsh Road Wilmington, DE 19810-4812	local: 1-302-478-3600
District of Columbia	**Delmarva Foundation for Medical Care** 1620 L Street, NW, Suite 1275 Washington, DC 20036	local: 1-202-293-9650 toll-free: 1-800-999-3362
Florida	**Florida Medical Quality Assurance** 4350 W. Cypress Street, Suite 900 Tampa, FL 33607	local: 1-813-354-9111 toll-free: 1-800-844-0795
Georgia	**Georgia Medical Care Foundation** 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346	local: 1-404-982-0411 toll-free: 1-800-982-0411

Appendix IV Quality Improvement Organizations (QIOs)

Hawaii	**Mountain-Pacific Quality Health Foundation** 1360 South Beretania Street Honolulu, HI 96814	local: 1-808-545-2550 toll-free: 1-800-524-6550
Idaho	**Qualis Health** 720 Park Boulevard, Suite 120 Boise, ID 83712	local: 1-208-343-4617 toll-free: 1-800-488-1118
Illinois	**Illinois Foundation for Quality Health Care** 2625 Butterfield Road, Suite 102E Oakbrook, IL 60523-1234	local: 1-630-571-5540 toll-free: 1-800-386-6431
Indiana	**Health Care Excel, Inc.** 2901 Ohio Boulevard, Suite 112 Terre Haute, IN 47803	local: 1-812-234-1499 toll-free: 1-800-288-1499
Iowa	**Iowa Foundation for Quality Health Care** 6000 Westown Parkway West Des Moines, IA 50266-7771	local: 1-515-223-2900 toll-free: 1-800-752-7014
Kansas	**Kansas Foundation for Medical Care** 2947 S.W. Wanamaker Drive Topeka, KS 66614-4193	local: 1-785-273-2552 toll-free: 1-800-432-0407
Kentucky	**Health Care Excel of Kentucky, Inc.** 1951 Bishop Lane, Suite 300 Louisville, KY 40218	local: 1-502-454-5112 toll-free: 1-800-288-1499
Louisiana	**Louisiana Health Care Review, Inc.** 8591 United Plaza Boulevard, Suite 270 Baton Rouge, LA 70809	local: 1-225-926-6353 toll-free: 1-800-433-4958
Maine	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
Maryland	**Delmarva Foundation for Medical Care** 7240 Parkway Drive, Suite 400 Hanover, MD 21076	local: 1-410-712-6083 toll-free: 1-800-492-5811
Massachusetts	**MassPRO** 245 Winter Street Waltham, MA 02451-1231	local: 1-781-890-0011 toll-free: 1-800-252-5533 *(in-state calls only)*

Appendix IV Quality Improvement Organizations (QIOs)

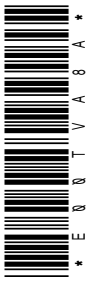
Michigan	**Michigan Peer Review Organization** 22670 Haggerty Road Suite 100 Farmington Hills, MI 48335-2611	local: 1-248-465-7300 toll-free: 1-800-365-5899
Minnesota	**Stratis Health** 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525	local: 1-952-854-3306 toll-free: 1-800-444-3423
Mississippi	**Mississippi Information and Quality Healthcare** Renaissance Place, Suite 504 385B Highland Colony Parkway Ridgeland, MS 39157-6035	local: 1-601-957-1575 toll-free: 1-800-844-0600
Missouri	**Primaris** 200 North Keene Street Columbia, MO 65201	local: 1-573-817-8300 toll-free: 1-800-735-6776
Montana	**Mountain-Pacific Quality Health Foundation** 3404 Cooney Drive Helena, MT 59602	local: 1-406-443-4020 toll-free: 1-800-497-8232
Nebraska	**CIMRO of Nebraska** 1230 O Street, Suite 120 Lincoln, NE 68508	local: 1-402-476-1399 toll-free: 1-800-247-3004
Nevada	**HealthInsight** 6830 W. Oguendo Road, Suite 102 Las Vegas, NV 89118	local: 1-702-385-9933 toll-free: 1-800-748-6773
New Hampshire	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820	local: 1-603-749-1641 toll-free: 1-800-772-0151
New Jersey	**Health Care Quality Strategies** 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-4026	local: 1-732-238-5570 toll-free: 1-800-624-4557 *(in-state calls only)*
New Mexico	**New Mexico Medical Review Association** 5801 Osuna Road, NE, Suite 200 Albuquerque, NM 87109	local: 1-505-998-9898 toll-free: 1-800-663-6351
New York	**IPRO** Health Care Quality Improvement Department 20 Corporate Woods Boulevard Albany, NY 12211-2370	local: 1-518-426-3300 toll-free: 1-800-233-0360 (option 3)

Appendix IV Quality Improvement Organizations (QIOs)

North Carolina	**Medical Review of North Carolina** 5625 Dillard Drive, Suite 203 Cary, NC 27511	toll-free: 1-800-722-0468
North Dakota	**North Dakota Health Care Review** 800 31st Avenue, SW Minot, ND 58701	local: 1-701-852-4231 toll-free: 1-888-472-2902
Ohio	**Ohio KePRO** Rock Run Center 5700 Lombardo Center Drive, Suite 100 Seven Hills, OH 44131	local: 1-216-447-9604 toll-free: 1-800-589-7337
Oklahoma	**Oklahoma Foundation for Medical Quality** 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600	local: 1-405-840-2891
Oregon	**Acumentra Health** 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201-4960	local: 1-503-279-0100 toll-free: 1-800-344-4354
Pennsylvania	**Quality Insights of Pennsylvania** 2601 Market Place Street, Suite 320 Harrisburg, PA 17110	local: 1-717-671-5425 toll-free: 1-877-346-6180
Puerto Rico	**QIPRO, Inc.** 2 Ponce de Leon Avenue, Suite 605 San Juan, PR 00918-1696	local: 1-787-641-1240 toll-free: 1-800-981-5062 *(PR calls only)*
Rhode Island	**Rhode Island Quality Partners, Inc.** 235 Promenade Street, Suite 500 Box 18 Providence, RI 02908	local: 1-401-528-3200 toll-free: 1-800-662-5028
South Carolina	**Carolina Center for Medical Excellence** 250 Berryhill Road, Suite 101 Columbia, SC 29210	local: 1-803-251-2215 toll-free: 1-800-922-3089 *(in-state calls only)*
South Dakota	**South Dakota Foundation for Medical Care** 1323 South Minnesota Avenue Sioux Falls, SD 57105	local: 1-605-336-3505 toll-free: 1-800-658-2285

Appendix IV Quality Improvement Organizations (QIOs)

Tennessee	**QSource** 3175 Lenox Park Boulevard, Suite 309 Memphis, TN 38115	local: 1-901-528-2655 toll-free: 1-800-489-4633
Texas	**TMF Health Quality Institute** 5918 West Courtyard Drive Barton Oaks Plaza Two, Suite 200 Austin, TX 78730-5036	local: 1-512-329-6610 toll-free: 1-800-725-9216
Utah	**HealthInsight** 348 E 4500 South, Suite 300 Salt Lake City, UT 84107	local: 1-801-892-0155 toll-free: 1-800-274-2290
Vermont	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
Virginia	**Virginia Health Quality Center** 4510 Cox Road, Suite 400 Glen Allen, VA 23060	local: 1-804-289-5320 toll-free: 1-800-545-3814
Washington	**QualisHealth** 10700 Meridian Avenue North, Suite 100 Seattle, WA 98133	local: 1-206-364-9700 toll-free: 1-877-575-8309
West Virginia	**West Virginia Medical Institute** 3001 Chesterfield Place Charleston, WV 25304	local: 1-304-346-9864 toll-free: 1-800-642-8686
Wisconsin	**MetaStar** 2909 Landmark Place Madison, WI 53713	local: 1-608-274-1940 toll-free: 1-800-362-2320
Wyoming	**Mountain-Pacific Quality Health Foundation** 2206 Dell Range Boulevard, Suite G Cheyenne, WY 82009	local: 1-307-637-8162 toll-free: 1-800-497-8232



Medco Health Solutions, Inc., 100 Parsons Pond Drive, Franklin Lakes, NJ 07417

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