

## 4. How to File a Grievance

### What is a Grievance?

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

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

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

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

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

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

### Who may file a grievance

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

### Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part D Grievances** (for complaints about Part D drugs) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this a formal grievance procedure.** If you have a

formal grievance, you may write to our grievance area. Please refer to Section 8 for contact information. Be sure to provide all pertinent information. (You also have the right to ask for a fast “expedited” grievance. See the section below entitled, “Fast Decisions” and Section 5 for further details pertaining to expedited complaints and appeals).

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

### Fast Grievances

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

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

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

## **5. Complaints and Appeals about your Part D Prescription Drug(s)**

### **Introduction**

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

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

### **PART 1. Requests for Part D drugs**

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

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

### **Initial Determinations**

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

The following are examples of requests for initial determinations:

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

Prescriptions Outside of Network" in Section 2 for a description of these circumstances.

## What is an exception?

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

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan.
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 2 (“Utilization Management”) to learn more about our additional coverage restrictions or limits on certain drugs.”
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D 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 Part D drug. Please note, if we grant your request to cover a Part D 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 Part D drugs that are in the specialty/self-injectable tier.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary or the Part D 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 Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

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

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

## Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your “appointed representative.” You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under “**Part D Coverage Determinations**” in Section 8. To learn how to name your appointed representative, you may call Customer Service.

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

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

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

### Asking for a standard decision

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

### Asking for a fast decision

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

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

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

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the

requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

## What happens when you request an initial determination?

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

Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as prior authorization, quantity limits, or step therapy requirements, we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

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

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

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

## What happens if we decide completely in your favor?

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

We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later

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

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

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

## What happens if we decide against you?

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

## Appeal Level 1: Appeal to the Plan

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

## Who may file your appeal of the initial determination?

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

## How soon must you file your appeal?

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

## How to file your appeal

### 1. Asking for a standard appeal

To ask for a standard appeal about a Part D drug a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

### 2. Asking for a fast appeal

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

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

## Getting information to support your appeal

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

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

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

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** (for appeals about Part D drugs) in [Section 8](#).

## How soon must we decide on your appeal?

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

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

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

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

### What happens if we decide completely in your favor?

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

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

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

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

### **Appeal Level 2: Independent Review Entity (IRE)**

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

### How to file your appeal

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

### How soon must the IRE decide?

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

### If the IRE decides completely in your favor:

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

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

### **Appeal Level 3: Administrative Law Judge (ALJ)**

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

#### **How to file your appeal**

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

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

#### **How soon will the Judge make a decision?**

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

#### **If the Judge decides in your favor:**

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

### **Appeal Level 4: Medicare Appeals Council (MAC)**

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

#### **How to file your appeal**

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

## How soon will the Council make a decision?

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

## If the Council decides in your favor:

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

## Appeal Level 5: Federal Court

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

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

## How to file your appeal

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

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

## How soon will the Judge make a decision?

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

## If the Judge decides in your favor:

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

## If the Judge decides against you:

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

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

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

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

## 8. Helpful Phone Numbers and Resources

### Contact Information for 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** 1-866-236-7376. Calls to this number are free.  
Hours of Operation: 24 hours a day, 7 days a week
- TTY/TDD** 1-800-236-1069. This number requires special telephone equipment. Calls to this number are free.
- WRITE** Caremark, P. O. Box 280200, Nashville, TN 37228 or e-mail us at  
**medicare.service@caremark.com**
- WEBSITE** [www.horizonblue.com/medicare](http://www.horizonblue.com/medicare)

### Contact Information for Grievances, Coverage Determinations and Appeals

#### Part D Coverage Determinations (about your Part D Prescription Drugs)

- CALL** 1-866-884-9477. Calls to this number are free.
- TTY/TDD** 1-866-236-1069. This number requires special telephone equipment. Calls to this number are free.
- FAX** 1-866-884-9475
- WRITE** Caremark, Medicare Appeals Department, MC 109, P. O. Box 52000,  
Phoenix, AZ 85072-2000.

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

### **Part D Grievances (about your Part D Prescription Drugs)**

- CALL** 1-866-249-6176. Calls to this number are free.
- TTY/TDD** 1-866-236-1069. This number requires special telephone equipment. Calls to this number are free.
- FAX** 1-866-788-5143
- WRITE** Caremark, Grievance Team, P.O. Box 280500, Nashville, TN 37228

For information about Part D grievances, see Section 4.

### **Part D Appeals (about your Part D Prescription Drugs)**

- CALL** 1-866-884-9477. Calls to this number are free.
- TTY/TDD** 1-866-236-1069. This number requires special telephone equipment. Calls to this number are free.
- FAX** 1-866-884-9475
- WRITE** Caremark, Medicare Appeals Department, MC 109, P. O. Box 52000, Phoenix, AZ 85072-2000

For information about Part D appeals, see Section 5.

## **Other important contacts**

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

### **State Health Insurance Assistance Program (SHIP)**

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. 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, and about Medigap (Medicare supplement insurance) policies.

This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact The SHIP in your state at The State Health Insurance Assistance Program, 807 West State Street, Trenton, New Jersey 08618; telephone number: 1-800-792-8820. You may also find the website for your local SHIP at [www.medicare.gov](http://www.medicare.gov) under “Search Tools” by selecting “Helpful Phone Numbers and Websites.”

### **Healthcare Quality Strategies, Inc.**

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

You may contact Healthcare Quality Strategies, Inc. at Healthcare Quality Strategies, Inc., 557 Cranbury Road, Suite 21, East Brunswick, NJ 08816; telephone number: 1-800-624-4557.

### **How to contact the Medicare program**

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

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit [www.medicare.gov](http://www.medicare.gov) for information. This is the official government website for Medicare. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under “Search Tools” for Medicare contacts in your state. Select “Helpful Phone Numbers and Websites.” If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer.

## **Medicaid**

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the New Jersey Department of Human Services, Quakerbridge Plaza, Building 7, P.O. Box 712, Trenton, NJ 08625-2600 or call 1-800-356-1561.

## **Social Security**

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

## **Pharmaceutical Assistance to the Aged and Disabled (PAAD) and New Jersey Gold Prescription Discount Program (Senior Gold)**

Pharmaceutical Assistance to the Aged and Disabled (PAAD) and New Jersey Gold Prescription Discount Program (Senior Gold) are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact PAAD and Senior Gold at:

New Jersey Department of Health and Senior Services  
Pharmaceutical Assistance to the Aged and Disabled (PAAD) or Senior Gold  
Lifeline and Special Benefit Programs  
P. O. Box 715  
Trenton, New Jersey 08625-0715  
1-800-792-9745

The website for PAAD or Senior Gold is [www.NJPAAD.gov](http://www.NJPAAD.gov).

## **Railroad Retirement Board**

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

## **Employer (or “Group”) Coverage**

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union 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 enroll in Medicare Part D. Call your employer/union 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.