Procedures that support safe prescribing

AmeriHealth utilizes an independent Pharmacy Benefits Management (PBM) company, FutureScripts®, to manage the administration of its commercial prescription drug programs. As our PBM, FutureScripts is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to our members and providers.

Prior Authorization

Prior authorization is a requirement that your physician obtain approval from your health plan for coverage of, or payment for, your medication. AmeriHealth requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the Pharmacy and Therapeutics Committee, a group of physicians and pharmacists from the area.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the member's prescribing physician, and the member's available prescription drug therapy history. Their evaluation may include a review of potential drug-drug interactions or contraindications, appropriate dosing and length of therapy, and utilization of other drug therapies, if necessary.

Without prior authorization, the member's prescription will not be covered at the retail or mail-order pharmacy (see 96-Hour Temporary Supply Program on following page). The prior authorization process may take up to two business days once complete information from the prescribing physician has been received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a member to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Currently, the following list of drugs is part of the prior authorization program. This list is subject to change and is updated quarterly. Prior authorization applies to all formulations of these specific drugs including, but not limited to, tablet, capsule, and oral suspension.

Abilify®, Absorica™, Abstral®, Acanya®, AcipHex®, Actemra®SC, Acticlate®, Actiq®, Aczone®, Adasuve®, Adcirca®, Adderall®, Addyi®, Adempas®, Adlyxin™, Adoxa®, Adrenaclick®, Advair®, Advair HFA, Advate®, Adynovate®, Aerospan™, Afinitor®, Afrezza®, Afstyla®, Alecensa®, Alphanate®, Alphanine® SD, Alprolix™, Alprolix® 250 Mg Vial, Altabax™, Alvesco®, Ambien®, Ambien CR® (12.5mg), Amerge®, Amitiza®, Ampyra™, Amrix®, Amturnide™, Anaprox® DS, Androderm®, Androgel®, Anoro™ Ellipta, Apidra®, Apidra Solostar, armodafinil, Arnuity Ellipta®, Arthrotec®, Ativan®, Atacand®/Atacand HCT®, Atralin®, Aubagio®, Auvi-Q®, Avapro®/ Avalide®, Avidoxy™, Avinza® (90mg and higher), Avita®, Axert®, Axiron®, Azelex®, Basaglar®, Bebulin®, Beconase AQ®, Belbuca™ (strengths greater than 300mcg), Belsomra®, Belviq®, Belviq XR, BeneFIX®, Benzaclin® 1-5% gel, Benzaclin® Pump, Benzamycin® gel, Benzamycinpak®, Bevespi aerosphere™, Beyaz®, Bosulif®, Bravelle®, Breo®, Breo Ellipta, Butrans™, Briviact®, Cabometyx™, Capex®, Caprelsa®, Carac®, Caverject®, Cayston™, Celebrex®, Cerdelega®, Cholbam®, Cialis®, Ciclodan®, Cimzia®, Cleocin T®, Clindagel®, Clobex®, Cloderm®, Coagadex®, Colcrys®, Cometriq™, Concerta®, ContraveER®, Copegus®, Cordran®, Corifact®, Corlanor®, Cosentyx™, Cotellic®, Cozaar®/ Hyzaar®, Cresemba® , Crestor®, Cuprimine®, Cutivate®, Cystaran™, Daklinza™, Daypro®, Daytrana™, Derma-Smoothe FS®, Desonate®, Desowen®, Desoxyn®, Dexedrine®, Dexilant™, Diabetic test strips[1], Dibenzyline®, Diclegis®, diclofenac gel 3%, Differin® Cream/Gel, Dilaudid® (4mg and higher), Diovan®, Diovan HCT®, Dolophine®, Doral®, Doryx® DR, Duac®, Dupixent®, Duragesic®, Durlaza®, Dymista®, EC-Naprosyn®, Ecoza™, Edarbi™, Edarbyclor™, Edex®, Edluar™, Effexor XR®, Elmiron® Eloctate™, Enbrel®, Enstilar®, Entresto™, Epclusa®, Erivedge™, Ertaczo®, Esbriet®, esomeprazole, eszopiclone (3mg), Eucrisa™, Evekeo™, Evoclin® foam, Evzio®, Exalgo™, Exelderm®, Exforge®/Exforge HCT®, Exjade®, Extavia®, Extina®, Factive®, Fanapt™, Farxiga™, Farydak®, Feiba®, fentanyl citrate, fentanyl, Fentora®, Ferriprox®, Fetzima™, Firazyr®, Flector® patch, Flovent®, Focalin XR®, Follistim®, Fortamet®, Forteo™, Fortesta™, Frova®, Fulyzaq™, Gattex®, Genotropin®, Gilenya®, Gilotrif™, Gleevec®, Gralise™, Grastek®, Halcion®, Halog®, Harvoni®, Helixate® FS, Hemofil®, Hetlioz™, Horizant™, Humalog®, Humate-P®, Humatrope®, Humira®, Humulin®, Hycamtin® capsules, hydromorphone 4mg and higher, hydromorphone er, Ibrance® , Iclusig™, Idelvion ®, Imbruvica™, Imitrex®, Inderal® LA, Inlyta®, Intermezzo®, Intuniv™, Invega™, Ixinity®, Jadenu™, Jakafi™, Jentadueto™, Jublia®, Kadian® strengths greater than 50 mg, Kalydeco™, Kapvay®, Kazano®, Kenalog™, Keppra®, Kerydin®, Keveyis®, Khedezla®, Kineret®, Koate®-DVI, Kogenate® FS, Korlym™, Kynamro®, Lamictal ODT ™, Lamictal®, Latuda®, Lazanda®, Lenvima™, Letairis®, Levitra®, Lexapro®, Lidoderm®, Lipitor®, Livalo®, Locoid® [lipocream], Loprox®, Lonsurf®, Lorzone®, Lunesta®, Luxiq®, Luzu®, Lynparza™, Lyrica®, Maxalt®, Mekinist®, Menopur®, Metadate CD®, Methadone, Micardis®/Micardis® HCT, Migranal®, Minastrin® FE, Minocin®, Mitigare®, Mobic®, modafinil, Monoclate-P®, Monodox®, Mononine®, Morphine Sulfate (Concentrate) SOLUTION 100 MG/5ML ORAL ,morphine sulfate extended release 24HR capsule (generic Kadian) 50mg and higher, morphine sulfate extended release tablet (generic MS Contin) 60mg and higher, morphine sulfate extended release capsule 24HR 90mg and higher), morphine sulfate ir (30mg), MS Contin® (strengths greater than 60mg), MUSE®, Myalept™, Naprelan®, Naprosyn®, Nasacort® AQ , Nascobal®, Nasonex®, Natesto™, Natpara®, Nesina®, Nexavar®, NexiumNinlaro®, Norditropin®, Northera®, Novoeight®, Novoseven® RT, Noxafil®, Nucynta® 75mg and 100mg, Nucynta® ER (strengths greater than 150mg), Nuedexta™, Nuplazid™, Nutropin®/Nutropin AQ®, Nuvigil®, Nuwiq®, Ocaliva™, Odomzo®, Ofev®, Oforta™, Olux®[E], Olysio™, Omnaris®, Omnitrope®, Onexton™, Onmel®, Onsolis™, Onzetra Xsail™, Opana® (10mg), Opana ER® (strengths greater than 15mg), Opsumit®, Oracea®, Oralair®, Orencia® SQ, Orenitram™, Orkambi™, Oseni®, Otezla™, Otrexup™, Oxistat®, oxycodone 15 mg and higher, oxycodone er (strengths greater than 30mg), oxycodone hcl 100 mg/5ml oral, oxycodone IR, Oxycontin® (strengths greater than 30mg), oxymorphone (10mg), oxymorphone ER 15 mg tab, oxymorphone ER (15mg and higher), Pandel®, Pegasys ProClick®, Penlac®, Pennsaid® 2% solution, Percocet®, Picato®, Pomalyst®, Prevacid®, Prevacid/ NapraPAC®, Prilosec®, Prilosec® suspension, Pristiq™, Proctocort® 30 mg supp, Procysbi®, Profilnine® SD, Protonix®, Proventil® HFA, Provigil®, Prozac®, Psorcon®, Pulmicort Flexhaler®, Pylera™, Qnasl™, Qsymia®, Qualaquin®, quinine sulfate, Ragwitek™, Rasuvo™, Ravicti™, Rayaldee®, Rayos®, Rebetol®, Rebif®, Recombinate™, Regimex®, Relistor®, Relpax®, Rescula®, Restoril®, Retin-A®, Retin-A Micro®, Revatio™, Revlimid®, Rexulti®, Riastap®, Ritalin LA®, Rixubis™, Roxicodone® , Rubraca®, Rybix™ ODT, Safyral®, Saizen®, Samsca™, Saphris®, Saxenda®, Sernivo™, Serostim®, Signifor®, sildenfil, Silenor®, Simponi™, Sirturo™, Sivextro™, Skelaxin®, Solaraze® Gel, Soliqua™, Solodyn®, Soma®, Sonata®, Sovaldi™, Sprycel®, Staxyn™, Stelara®, Stendra™, Stiolto Respimat™, Stivarga®, Strensiq®, Striant®, Subsys®, Suprenza™ ODT, Sumavel™, Sutent®, Sylatron™, Symlin®, Synalar® Solution, Syprine®, Taclonex®, Taclonex® Scalp, Tafinlar®, Tagrisso™, Taltz Autoinjector®, Tanzeum™, Tarceva®, Targadox™, Targretin® Gel, Tasigna®, Technivie™, Tekamlo™, Tekturna®/Tekturna HCT®, Temodar® Oral, Tenoretic®, Tenormin®, Testim®,Teveten®/Teveten® HCT, Tev-Tropin®, Thalomid®, Thiola®, Topicort®, Toviaz™, Tracleer®, Tradjenta™, Tretten®, Treximet™, Trintellix, Twynsta®, Tykerb®, Tyvaso®, Uloric®, Ultravate®, Uptravi®, Utibron™ Neohaler, Uloric®, Valchlor™,Valium®, Valtrex™, Vanos™, Vecamyl™, Veltin™, Venclexta®, Ventavis®, Ventolin® HFA, Viagra®, Viberzi™, Vibramycin®, Viekira Pak™, Viekira XR, Viibryd®, Voltaren-XR®, Vonvendi®, Votrient™, Vraylar™, Vusion®, Vytorin®, Wellbutrin® XL, Wilate® 500Unit-500Unit, 1,000Unit-1,000Unit, Vial, Xalkori®, Xanax®, Xeljanz®, Xenazine™, Xifaxan® 550 mg, Xigduo XR™, Xiidra™, Xolegel®, Xoponex HFA®, Xtandi®, Xuriden™, Xyntha®, Xyrem®, Zanaflex®, Zavesca®, Zecuity®, Zelboraf®, Zembrace Symtouch™, Zepatier™, Zetonna®, Ziana®, Zinbryta™, Zioptan™, Zipsor™, Zmax™, zolpidem, zolpidem ER (12.5mg), Zolinza®, Zoloft®, Zolpimist™, Zomacton™ (5 mg vial), Zomig®, Zorbtive™, Zurampic® 200 mg, Zydelig®, Zykadia™, Zytiga™, Zyvox®

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[1] All diabetic test strips require prior authorization except the following: Autodisc®, Ascencia®, Breeze® 2, Contour®, Contour NEXT, Elite®, FreesStyle®, FreeStyle Lite®, and Precision Xtra®.

*All brand prenatal vitamins require prior authorization.

*Compound products with total cost equal to or greater than $75 per prescription.

Drug list is current as of 7/1/2017

Age

The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and to ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals age 5 and older, such as Zafirlukast. The pharmacist's computer provides up-to-date information about FDA rules. If the member's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request preapproval of restricted medications when medically necessary. The approval criteria for this review were developed and endorsed by the Pharmacy and Therapeutics Committee. The member should contact the prescribing physician to request that the physician initiate the preapproval process. To determine if a covered prescription drug prescribed for you has an age limit, call FutureScripts at the number on the back of your ID card or see the plan website at amerihealth.com/rx

Quantity level limits

Quantity level limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses and length of therapy of a particular drug. We have several different types of quantity level limits that are explained in detail below.

Quantity Over Time. This quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and a member went to the pharmacy on January 1, 2017, for one of these medications, the computer system would have looked back 30 days to December 2, 2016, to see how much medication was dispensed. The purpose of these limits is to help keep excessive quantities from being dispensed. Examples of quantity limits over time are:

- Nuvaring® = 1 ring per 28 days
- Ibandronate 150mg (Boniva®) 150mg = 1 tablet per 30 days
- Amerge® (nine 2.5mg tablets per 30 days), Imitrex® (eighteen 50mg tablets per 30 days), Maxalt® (twelve 10mg tablets per 30 days), Migranal® (eight 4mg nasal spray units per 30 days), and Zomig® (nine 5mg tablets per 30 days)
- Diabetic supplies such as blood glucose test strips (#200 strips per 30 days) and lancets (#200 lancets per 30 days)

Maximum daily dose. This quantity limit is based on maximum number of units of the drug allowed per day. For example, if a member went to a pharmacy for one of these medications, the computer system will ensure that the amount of medication being requested per day does not exceed the maximum daily dose. Examples of maximum daily dose quantity limits are:

- Sedative hypnotic drugs, such as Sonata® (1 capsule per day) and Ambien® (1 tablet per day)
- Oral narcotic drugs, such as OxyContin® (3 tablets per day), Percocet® (6 tablets per day), and Percodan® (6 tablets per day)
- Proton pump inhibitor drugs, such as Nexium® (1 capsule per day) and Protonix (1 tablet per day)

Refill too soon. This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. Based on this edit, a member is able to receive a refill of a prescription after 75% utilization. However, if the same prescription is refilled every month at the 75% utilization point, an excess supply will be accumulated. The plan will "look back" over a period of 180 days and calculate the total day supply that has been dispensed.

Therapeutic drug class. This limit is a day supply limit that applies to some classes of drugs, such as narcotics (i.e., short-acting and long-acting products). If a member uses more than one drug within the same class, he or she may be unsafely duplicating drugs and would be affected by the total day supply limit for a therapeutic drug class. Members will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.

If a physician requires that a member needs a medication therapy that exceeds any of the utilization limits described above, the physician must request a quantity limit override. The member is required to contact the prescribing physician to initiate a prior authorization request for an override.

If the exception for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a member to continue the drug therapy as requested after the expiration date, a new request for a prior authorization needs to be submitted and approved in order for coverage to continue.

To determine if a covered prescription drug prescribed for you has a quantity limit or requires prior authorization, call FutureScripts at the phone number on the back of your ID card or see the plan website at amerihealth.com/rx

96-hour Temporary Supply Program

The 96-hour Temporary Supply Program applies to the following covered medications:

- Most medications that require prior authorization
- Medications that are subject to age limits (preapproval required for ages outside of recommended ranges)

Under the 96-hour Temporary Supply Program, if a member's doctor writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity level limit for a medication, and prior authorization/pre-approval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the member with no out-of-pocket cost-sharing at that time.[1]
2. By the next business day, our PBM will contact the member's doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by our PBM, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled and the appropriate prescription drug out-of-pocket cost-sharing will be applied.[1]
5. If denied, notification will be sent to the doctor and the member.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved. Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations such as Retin-A® (tube), Enbrel® (2-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs.

The process for requesting a prior authorization/preapproval or override is as follows:

- The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and submits it to our PBM by fax at 1-888-671-5285. A member's physician may request the form by calling 1-888-678-7012. Members may request the form through Customer Service on behalf of their physician, but it must be completed and submitted by the doctor.
- The PBM will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.
- If approved, the prescribing physician will be notified of approval via fax or telephone and the claims system will be coded with the approval.
- Members may call the Customer Service phone number on their identification card to determine if the prescription is approved.
- If denied, the prescribing physician will be notified via letter, fax, or telephone.
- Members are also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to members and physicians.

[1] Members with an integrated drug benefit (e.g., CMM and Major Medical) will pay the discounted cost of the 96-hour supply as well as the remainder of the prescription order (if approved) at the time of purchase, and the medical claim for reimbursement will be processed through standard procedures.

Coverage for medications not on the formulary (specific to Select Drug Program® members only)

Providers may request formulary coverage of a covered non-formulary medication when all formulary alternatives have been exhausted or there are contraindications to using the formulary alternatives. The provider should complete the covered non-formulary appeal form providing detail to support use of the covered non-formulary medication and should fax the request to 1-888-671-5285. If the non-formulary request is approved, the drug will be paid at the appropriate formulary benefit level. If the request is denied, the member and provider will receive a denial letter with the appropriate appeals language. Whether or not an appeal is filed, the member may always obtain benefits for the covered non-formulary drug at the appropriate non-formulary benefit level. Out-of-pocket expenses for non-formulary drugs are higher than for formulary drugs.

Appealing a decision

If a request for prior authorization/preapproval or override results in a denial, the member or physician, on the member's behalf, may file an appeal. Both the member and their provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. In all cases, the physician needs to be involved in the appeals process to provide the required medical information for the basis of the appeal.

Prescription Drug Program provider payment information

FutureScripts is the Pharmacy Benefits Management (PBM) that administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Independence anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member copayment.

AmeriHealth

#007645 131080 PTSSP AH Group-Indiv. (6/17)

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.