cigna healthcare

Evidence of coverage

January 1 - December 31, 2024

Your Medicare Health Benefits and Services as a Member of Cigna True Choice Core Medicare (PPO)

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-888-281-7867 for additional information. (TTY users should call 711) Hours are October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.

This plan, Cigna True Choice Core Medicare (PPO), is offered by Cigna Healthcare. (When this *Evidence of Coverage* says "we," "us," or "our," it means Cigna Healthcare. When it says "plan" or "our plan," it means Cigna True Choice Core Medicare (PPO).)

This document is available for free in Spanish.

To get information from us in a way that works for you, please call Customer Service. We can give you information in braille, in large print, or other alternate formats if you need it.

Benefits, and/or copayments/coinsurance may change on January 1, 2025.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost-sharing;
- Your medical and prescription drug benefit;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and
- Other protections required by Medicare law.

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OMB Approval 0938-1051 (Expires: February 29, 2025)

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Cigna True Choice Core Medicare (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Cigna True Choice Core Medicare (PPO). We are required to cover all Original Medicare Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

Cigna True Choice Core Medicare (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Cigna True Choice Core Medicare (PPO) does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment. The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Cigna True Choice Core Medicare (PPO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused or concerned or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* and the *Evidence of Coverage Snapshot* are part of our contract with you about how our plan covers your care. Other parts of this contract include any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in our plan between January 1, 2024 and December 31, 2024. Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2024. We can also choose to stop offering the plan in your service area after December 31, 2024.

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

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- — and — You live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it
- — and — You are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for our plan

Our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

A customer is eligible to enroll in the Cigna True Choice Core Medicare (PPO) as long as the enrollee permanently resides in the Cigna Medicare service area, which includes all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

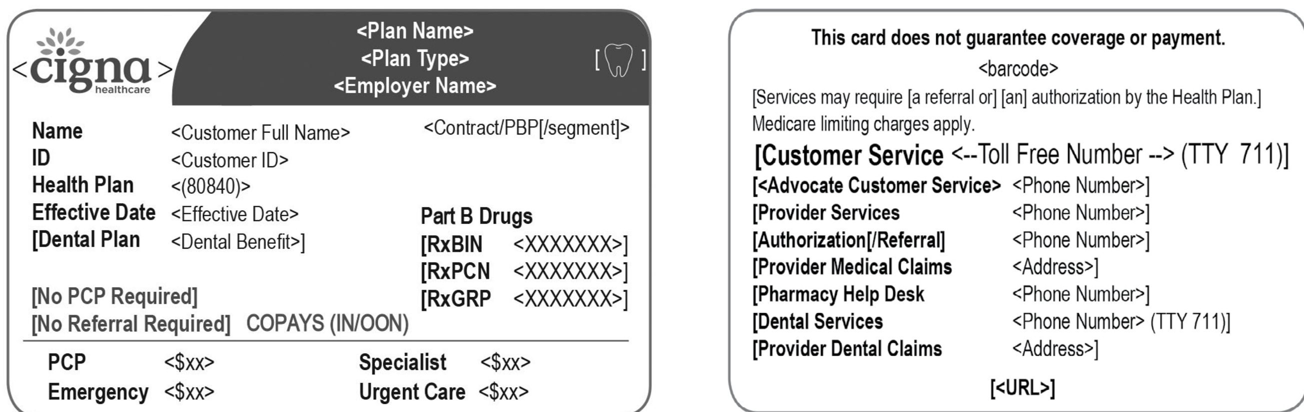
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Cigna True Choice Core Medicare (PPO) if you are not eligible to remain a member on this basis. Cigna True Choice Core Medicare (PPO) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Cigna True Choice Core Medicare (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical search studies, also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2 Provider and Pharmacy Directory: Your guide to all providers in the plan's network

The Provider and Pharmacy Directory lists our network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

With this plan, you may use network and out-of-network providers to get your medical care and services.

If you don't have a copy of the *Provider and Pharmacy Directory,* you can request a copy from Customer Service. You can also find this information on our website at cignamedicare.com/group/maresources.

SECTION 4 Your monthly costs for your plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Section 4.1 Plan premium

Please refer to your Plan Sponsor for information on your monthly premium.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Please refer to your Plan Sponsor and the *Evidence of Coverage* Snapshot for information on your Plan Premium.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year your plan sponsor will tell you and the change will take effect on January 1.

SECTION 5 More information about your monthly premium

Section 5.1 Your coverage is provided through a contract with your current employer or former employer or union.

Please contact the employer's or union's benefits administrator for information about your plan premium.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, your plan sponsor will tell you and the change will take effect on January 1.

SECTION 6 Keeping your plan membership record up to date

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Plan contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to our plan's Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.* Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
FAX	1-888-766-6403
WRITE	Cigna Healthcare Attn: Medicare Customer Service, P.O. Box 20012, Nashville, TN 37202-9919
WEBSITE	cignamedicare.com/group/maresources

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays*.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
FAX	1-888-766-6403
WRITE	Cigna, Attn: Precertification Department, P.O. Box 20002, Nashville, TN 37202

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Complaints about Medical Care – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
WRITE	Cigna, Attn: Medicare Grievance Dept., P.O. Box 188080, Chattanooga, TN 37422
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, see Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services).*

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests – Contact Information
WRITE	Cigna, Attn: Direct Member Reimbursement, Medical Claims, P.O. Box 20002, Nashville, TN 37202
WEBSITE	cignamedicare.com/group/maresources

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. 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. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Refer to Appendix A for a list of SHIP programs.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://shiphelp.org (Click on SHIP LOCATOR in middle of page.)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Refer to Appendix B for a list of QIOs.

A QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve

the quality of care for people with Medicare. A QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or ESRD and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" are:

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

To find out more about Medicaid and its programs, refer to Appendix C.

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:
Using the plan for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the *Evidence of Coverage* Snapshot.

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in the *Evidence of Coverage Snapshot*.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (please refer to the *Evidence of Coverage* Snapshot).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more information about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider and Pharmacy Directory*.
  - If you use an out-of-network provider, you may have to pay the doctor for the full allowable amount and then submit your claim to Cigna for reimbursement. Cigna will reimburse you for the cost of the claim less your copay or coinsurance.
  - Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Primary Care Physician (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

As a member of our plan, you do not have to choose a network Primary Care Physician (PCP); however, we strongly encourage you to choose a PCP and let us know who you choose. Your PCP can help you stay healthy, treat illnesses and

coordinate your care with other health care providers. Depending on where you live, the following types of providers may act as your PCP:

- General Practitioner
- Family medicine
- Internal medicine
- Geriatrics

Your PCP will provide most of your care, and they will coordinate your care with other providers when you need more specialized services. They will help you find a specialist and will help arrange the covered services you get as a member of our plan. Some of the services that the PCP will coordinate include:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions

"Coordinating" your services includes consulting with other plan providers about your care and how it's progressing. Since your PCP will provide and coordinate most of your medical care, we recommend that you have your past medical records sent to your PCP's office.

In some cases, your PCP or other provider may need to get approval in advance from our plan's Medical Management Department for certain types of services or tests (this is called getting "prior authorization"). Services and items requiring prior authorization are listed in the Medical Benefits Chart in the *Evidence of Coverage Snapshot*. Prior authorization is not required for covered services received out-of-network; however, you or your doctor may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary by calling Customer Service (phone numbers are on the back cover of this booklet).

How do you choose your PCP?

You can select your Primary Care Physician (PCP) by choosing from those listed in our plan's *Provider and Pharmacy Directory*; the most updated list can be found on our website at cignamedicare.com/group/maresources. If you need help, you can call Customer Service for assistance. You can also change your PCP (as explained later in this section) by contacting Customer Service.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

To change your PCP, call Customer Service at the number printed on the back of this document before you set up an appointment with a new PCP. When you call, be sure to tell Customer Service if you are seeing specialists or currently getting other covered services that were coordinated by your PCP (such as home health services and durable medical equipment). They will check to see if the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP, let you know the effective date of your change request, and answer your questions about the change.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get any services that are medically necessary without getting approval in advance from your PCP.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.

- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

If you choose to select a PCP, your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. Your PCP may refer you to a specialist, but you can go to any of our specialists in our plan's network without a referral. Selection of a PCP does not limit you to specific specialists or hospitals to which that PCP refers. Please refer to our website at cignamedicare.com/group/maresources for a complete listing of PCPs and other participating providers in your area. You can also contact Customer Service at the phone number listed on the back cover of this booklet.

In some cases, your PCP or other provider may need to get approval in advance from our Medical Management Department for certain types of services or tests that you receive from network providers (this is called getting "prior authorization"). Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in the Medical Benefits Chart in the *Evidence of Coverage Snapshot*. Prior authorization is not required for covered services received out-of-network; however, if we later determine that the services you received were not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. You or your doctor may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary by calling Customer Service.

Prior authorization may be needed for certain services (please see the *Evidence of Coverage Snapshot* for information which services require prior authorization). Authorization can be obtained from the plan. You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

If you do not have an advanced determination, authorization can also be obtained from a network provider who refers you to a specialist outside the plan's network for a service; provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.

What if a specialist or another network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost-sharing.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.4 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover

services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint))* to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services)* for information about what to do if you receive a bill or if you need to ask for reimbursement.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license, even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at the toll-free number on the back of your membership card. Hours are October 1 – March 31, 8:00 a.m. –8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. TTY users should call 711. Additionally, you should call your PCP. Your PCP's phone number may be on the front of your membership card.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over. After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care — thinking that your health is in serious danger — and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

Section 3.2 Getting care when you have urgent need for services

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

For a list of urgent care centers in our network, please refer to our *Provider and Pharmacy Directory*. You can call Customer Service for information on how to access urgent care centers.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.cigna.com/medicare/disaster-policy for information on how to obtain needed care during a disaster.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services)* for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in the *Evidence of Coverage Snapshot* of this document. If you receive services not covered by our plan or services that were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, you may have to pay the full cost of any skilled nursing facility care you get after our plan's payment reaches the benefit limit. Once you have used up your benefit limit, additional payments you make for the service do not count toward your annual out-of-pocket maximum.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works.

Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost-sharing for the services in that trial. If, for example, you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost-sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it is part of the research study
- Treatment of side effects and complications of the new care

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost-sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify the plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, which is the same amount you would pay under our plan's benefits. Please note that in order to receive payment from the plan, you must submit documentation to the plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- New items or services that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - — *and* — you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (please refer to the *Evidence of Coverage Snapshot*).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in our plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 consecutive payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments whether to our plan or to Original Medicare do not count.

Section 7.2 Rules for oxygen equipment, supplies and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, our plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart
(what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter refers to the Medical Benefits Chart which is found in the *Evidence of Coverage* Snapshot that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for covered services.

- A **"deductible"** is the amount you must pay for covered services before the plan will begin to pay. (The Medical Benefits Chart in the *Evidence of Coverage Snapshot* tells you more about your deductible.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in the *Evidence of Coverage* Snapshot tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in the *Evidence of Coverage* Snapshot tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Please refer to your *Evidence of Coverage* Snapshot to learn about the most you will pay for Medicare Part A and Part B covered medical services.

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may add additional separate charges, called "balance billing". This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Customer Service.

SECTION 2 Use the Medical Benefits Chart to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart in the *Evidence of Coverage* Snapshot that we mailed to you lists the services our plan covers

and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment and Part B prescription drugs) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider or an out-of network provider who participates in the Medicare program, you pay your copay or coinsurance according to your benefits, and your health care provider bills Cigna Healthcare for the rest.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay your copay or coinsurance. Cigna Healthcare will pay the rest of the cost of your covered services, including excess charges, up to the Medicare-set limit.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment may apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are “excluded” from Medicare coverage and therefore, may not be covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service. Refer to your *Evidence of Coverage Snapshot* to see what services are covered by your plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture.		✔ Covered for chronic low back pain
Cosmetic surgery or procedures.		✔ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care is care provided in a nursing home, hospice or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✔	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✔ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✔	
Full-time nursing care in your home.	✔	
Home-delivered meals.		✔ Medical Benefits Chart in the *Evidence of Coverage Snapshot* for more information.
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✔	
Naturopath services (uses natural or alternative treatments).	✔	
Orthopedic shoes.		✔ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✔	
Private room in a hospital.		✔ Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✔	
Routine chiropractic care.		✔ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care.		✔ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Radial keratotomy, LASIK surgery and other low vision aids. (Please refer to the Medical Benefits Chart in the *Evidence of Coverage Snapsho*t for vision services covered by our plan.)		✔ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Services considered not reasonable and necessary, according to the standards of Original Medicare.	✔	
Supportive devices for the feet.		✔ Orthopedic or therapeutic shoes for people with diabetic foot disease.

CHAPTER 5:
Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of the cost-sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than the plan-allowed cost-sharing. If this provider is contracted you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. **When you've received medical care from a provider who is not in our plan's network**
   When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.
   - You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
   - Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.
2. **When a network provider sends you a bill you think you should not pay**
   Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.
   - You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
   - Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
   - If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.
3. **If you are retroactively enrolled in our plan**
   Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)
   If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after

your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (cignamedicare.com/group/maresources) or call Customer Service and ask for the form. You must submit your claim to us within 12 months of the date you received the service, item, or drug.

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

Cigna
Attn: Direct Member Reimbursement, Medical Claims
P.O. Box 20002
Nashville, TN 37202

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

Section 3.1 We check to see whether we should cover the service and how much we owe

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter that explains the reasons why we are not sending the payment you have requested and your right to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.) Debemos proporcionarle información de manera que la entienda bien (en otros idiomas que no sea inglés, en braille, en impresión con letra grande o en otros formatos, etc.)

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost-sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Member Grievances department (phone numbers are printed in the Complaints About Medical Care contact information in Chapter 2, Section 1 of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Para obtener mayor información de nuestra compañía en la manera que más le convenga, llame al Servicio de Atención al Cliente (los números telefónicos se encuentran en la contraportada de este libro).

Nuestro plan cuenta con personal y servicio gratuito de intérprete de idiomas que podrá responder a las preguntas de los miembros que no hablen inglés y de los miembros que tengan alguna discapacidad. Además, podemos darle información en braille, en impresión con letra grande, o en otros formatos sin costo si así lo necesita. Es nuestra obligación darle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información de nuestra compañía en la manera que más le convenga, llame al Servicio de Atención al Cliente (los números telefónicos están impresos en la contraportada de este libro).

Si tiene dificultades para conseguir información de nuestro plan en un formato que sea accesible y adecuado para usted, puede presentar una queja por agravios comunicándose con nuestro departamento de quejas por agravios para miembros (Member Grievances department); los números telefónicos se encuentran impresos en la información de contacto bajo el título "Quejas sobre su atención médica" en el Capítulo 2, Sección 1 de este libro. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto está incluida en esta Constancia de cobertura o en este correo, o puede comunicarse con el Servicio de Atención al Cliente (los números telefónicos están impresos en la contraportada de este libro) para solicitar más información.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You also have the right to get non-emergency care after your PCP's office is closed. If you need to talk with your PCP or get medical care when the PCP office is closed, and it is *not* a medical emergency, call the PCP at the phone number found on your membership card. There is always a doctor on call to help you. The Telecommunications Relay Service (TRS) provides

a relay service for deaf, hard-of-hearing and/or persons with speech and language disorders by dialing 711. The TRS will assist you in contacting your PCP.

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

Cigna's Evaluation of New Technologies

We take pride in giving our customers the best medical and pharmacy benefits available. Our Pharmacy & Therapeutics Committee and our Clinical Guidelines Committee carefully review new medications, medical and behavioral procedures, and devices as potential benefit additions for our customers. The Pharmacy & Therapeutics Committee is made up of practicing physicians, pharmacists, and our Medical Directors. Together, these professionals review new medications while evaluating available clinical guidelines, evidence-based medicine, and pharmacoeconomic studies. The Clinical Guidelines Committee is made up of our Medical Directors, pharmacists and behavioral health specialists. This committee evaluates medical and behavioral technologies by reviewing pertinent data including evidence-based guidelines, safety data, appropriate CMS and other regulatory information, and expert specialist input. Based on these reviews, the committees then vote on which medications, medical and behavioral procedures, and devices to offer that are deemed efficacious and efficient and will provide the greatest benefit for our customers.

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service.

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

Section 1.5 We must support your right to make decisions about your care

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

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives".** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint a state-specific agency such as a State Health Insurance Assistance Program (SHIP) or Quality Improvement Organization (QIO). Please refer to Appendix A and Appendix B in the back of this booklet to find contact information for the State Health Insurance Assistance Program (SHIP) or Quality Improvement Organization (QIO) in your state.

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

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service**.
- You can **call the SHIP**.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service**.
- You can **call the SHIP**.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.);
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

You have the right to make recommendations regarding Cigna's member rights and responsibilities policy.

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service. We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the *Evidence of Coverage Snapshot* to learn what is covered for you and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give the details about medical services.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:
What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

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

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

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

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "independent review organization" instead of "Independent Review Entity."
- It also uses abbreviations as little as possible.

However, it can be helpful — and sometimes quite important — for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations you may also want help or guidance from someone who is not connected with us. **Below are two entities that can assist you.**

State Health Insurance Assistance Program (SHIP).

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do. The services of SHIP counselors are free. You will find phone numbers and website URLs in Appendix A.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

(This includes problems about whether medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, if your plan network doctor refers you to a medical specialist, this is a (favorable) coverage decision.

If your doctor, whether the doctor is in our network or outside it, is unsure whether we will cover a medical service, you or your doctor can contact us and ask for a coverage decision prior to receiving the service. This is called an "advanced determination," or prior authorization. You or your doctor can also request that the response be in writing if you would like a copy of the decision for your records. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make an initial coverage decision for you. If your plan denies the coverage asked about in the advanced determination, then your plan must issue a standardized denial notice informing you or your doctor of your right to appeal this decision.

If you do not have an advanced determination, authorization for services can also be obtained from a network provider who refers an enrollee to a specialist. This can also be a provider outside of the plan's network. However, the service cannot be a service that is explicitly (that is, never covered by the plan) as discussed in Chapter 4. If the enrollee receives an authorization from the provider and the service is not an excluded service, the enrollee only has to pay plan-cost-sharing. If the plan attempts to charge the enrollee more, the enrollee can formally request a review called an appeal. This is discussed in the next section.

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

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, your appeal will automatically go on to Level 2. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal to Level 2 if we do not fully agree with your Level 1 appeal.) If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Customer Service**.
- You **can get free help from** your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" *(Applies to these services only:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision, Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision, Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an Appeal, Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill, Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal, Section 5.3.**

Note: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read Sections 7 and 8 of this chapter. Special rules apply to these types of care. Here's what to read in those situations:

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."** A "fast coverage decision" is called an **"expedited determination."**

<u>Step 1:</u> Decide if you need a "standard coverage decision" or a "fast coverage decision."

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision

   - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

<u>Step 2:</u> **Ask our plan to make a coverage decision or fast coverage decision**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor or your representative can do this. Chapter 2 has contact information.

<u>Step 3:</u> **We consider your request for medical care coverage and give you our answer.**

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drugs**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.).

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or services. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

<u>Step 4:</u> **If we say no to your request for coverage for medical care, you can appeal.**

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

Section 5.3 Step-by-step: How to make a Level 1 Appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."** A "fast appeal" is also called an **"expedited reconsideration."**

<u>Step 1:</u> **Decide if you need a "standard appeal" or a "fast appeal."**

A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

<u>Step 2:</u> Ask our plan for an Appeal or a Fast Appeal.

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

<u>Step 3:</u> We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.

- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Terms
The formal name for the **"Independent Review Organization"** is the "Independent Review Entity." It is sometimes called the **"IRE."**

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the Independent review organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests. For expedited requests**, we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter.")
    - Explaining its decision.

- ▫ Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- ▫ Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.)
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **"discharge date."**
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. These experts are not part of our plan.

<u>Step 1:</u> Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received *(An Important Message from Medicare About Your Rights)* tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Appendix B.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
  - If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said no to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

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

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must (pay you back) for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are **getting home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Terms
"Notice of Medicare Non-Coverage." It tells you how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you.
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You or someone who is acting on your behalf will be asked to sign the written notice to show that you received it.**
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

<u>Step 1:</u> Make your Level 1 Appeal: Contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received *(Notice of Medicare Non-Coverage)* tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms
This notice of explanation is called the **"Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage**, from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then we must keep providing your covered services for as long as it is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal — and you choose to continue getting care after your coverage for the care has ended — then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, (for a total of five levels of appeal) If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as they are medically necessary. It also means that we have agreed to

reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or
- Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say no to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step-by-Step: Level 2 *Alternate* appeal Process

- During the Level 2 Appeal, an **Independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision we made should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal **The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.**

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

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

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with Customer Service? • Do you feel you are being encouraged to leave the plan?
Complaint	**Example**
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? ▫ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples. • You have asked for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

- A **"complaint"** is also called a **"grievance."**
- **"Making a complaint"** is also called **"filing a grievance."**
- **"Using the process for complaints"** is also called **"using the process for filing a grievance."**
- A **"fast complaint"** is also called an **"expedited grievance".**

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Submit your **written complaint** to the following address: Cigna, Attn: Medicare Grievance Dept., P.O. Box 188080, Chattanooga, TN 37422 or you may email your grievance to: Member.Grievances@cigna.com.
  For standard grievances received in writing, we will respond to you in writing within 30 calendar days of receipt of your written grievance. For expedited grievances, we must decide and notify you within 24 hours (see "fast complaint" below).
- The deadline for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options.

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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.
  - Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost-share until your membership ends.

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

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

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans.
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

    OR
  - Original Medicare *without* a separate Medicare prescription drug plan.
- Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make one change to your health coverage during the **Medicare Advantage Open Enrollment Period.**

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

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

You may be eligible to end your membership during a Special Enrollment Period If any of the following situations apply to you. These are just examples; for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.

- If you have Medicaid.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

The enrollment periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

When will membership end? on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service.**
- You can find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

The table below shows how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

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

Until your membership ends and your new Medicare coverage goes begins, you must continue to get your medical care through our plan.

- **Continue to use our network providers to receive medical care.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Cigna must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Cigna must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Cigna cannot ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

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

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Cigna, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about subrogation and third party recovery

If we make any payment to you or on your behalf for Covered Services (see Chapter 10 for definition), we are permitted to be fully subrogated (a legal principle that allows the plan to be reimbursed for certain payments we have made on your behalf, in certain circumstances) to any and all rights you have against any person, entity or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness or condition. We are given the same rights of subrogation and recovery that are available to the Medicare Program under the Medicare Secondary Payer rules. We may use whatever rights of recovery are available to the Medicare program under 42 U.S.C. § 1395mm(e)(4), 42 U.S.C. §1395w-22(a)(4), 42 C.F.R. Part 411, and 42 C.F.R. Part 422.

Once we have made a payment for Covered Services, we will have a lien on the proceeds of any judgment, settlement, or other award or recovery you may receive or be entitled to receive, including but not limited to the following:

Any award, settlement, benefits or other amounts paid under any workers' compensation law or award;

Any and all payments made directly by or on behalf of a third party tortfeasor or person, entity or insurer responsible for indemnifying the third party tortfeasor;

Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

You agree to cooperate with us and any of our designated representatives and to take any actions or steps necessary to secure our lien/interests, including but not limited to:

Fully responding to requests for information about any accidents or injuries;

Fully responding to our requests for information and providing any relevant information that we have requested; and

Fully participating in all phases of any legal action we may need to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to affect our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior authorized written consent. Your failure to cooperate shall be deemed a violation or breach of your obligations, and we may seek any available legal action against you to protect our rights.

We are also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under the Plan. You must immediately pay to us any amounts you get by judgment, settlement, award, recovery or otherwise from any third party or his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in this Plan.

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, impacted or eliminated by the “made whole” doctrine or any other doctrine that may apply.

We are not required to pursue subrogation or reimbursement either for our benefit or on your behalf. Our rights under this Evidence of Coverage shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you seek relating to your injury, illness, or condition.

If you disagree with any decision or action we take in connection with the subrogation and third party recovery provisions outlined above, you must follow the procedures explained in Chapter 9 of this booklet: What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

SECTION 5 Report Fraud, Waste and Abuse

Health care fraud is a violation of federal and/or state law. If you know of or suspect health insurance fraud, please report it by calling our Compliance and Ethics Hotline at 1-800-472-8348. You are not required to identify yourself when you report the information. The hotline is anonymous.

CHAPTER 10:
Definitions of Important words

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that our plan measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network providers and out-of-network providers. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time period in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example, $10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

Covered Services – All of the health care services and supplies that are covered by our plan.

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

Deductible – The amount you must pay for health care before our plan begins to pay.

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).

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

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

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

Grievance – A type of complaint you make about our plans, providers or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services, as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Independent Physician Association (IPA) – An Independent Physician Association is a group of primary and specialty physicians who work together in coordinating your medical needs. See Chapter 1, Section 8.1 for more information about Independent Physician Associations.

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

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from in-network and out-of-network providers. After you have reached this limit, you will not have to pay anything when you get covered services from in-network and out-of-network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network provider.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medical Group – An association of primary care physicians (PCPs), specialists and/or ancillary providers (such as therapists and radiologists) that the plan contracts with to provide care as one unit. Medical groups can be a single specialty (e.g., all PCPs) or multispecialty (e.g., PCPs and specialists).

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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

Medicare Advantage Open Enrollment Period – The set time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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

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

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

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

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **"Network providers"** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network Provider or Out-of-network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. In addition, Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – In this document, a Preferred Provider Organization is a Medicare Advantage Plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network providers and a higher limit on your total combined out-of-pocket costs for services from both network and out-of-network providers.

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

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

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

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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

Special Needs Plan (SNP) – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

APPENDIX

Appendix A: State Health Insurance Assistance Programs (SHIP) contact information

Alabama

Alabama State Health Insurance Assistance Program

CALL 1-800-243-5463

WRITE Alabama State Health Insurance Assistance Program, Alabama Department of Senior Services, 201 Monroe Street, Suite 350, Montgomery, AL 36104

WEBSITE www.alabamaageline.gov

Alaska

State Health Insurance Assistance Program

CALL 1-907-269-3680 or 1-800-478-6065

TTY 1-800-770-8973

WRITE State Health Insurance Assistance Program, Alaska Dept. of Health and Social Services, Senior & Disabilities Services, 550 W. 7th Avenue, Suite 1230 Anchorage, AK 99501

WEBSITE http://medicare.alaska.gov

Arizona

State Health Insurance Assistance Program

CALL 1-602-542-6439 or 1-800-432-4040

TTY 711.0

WRITE State Health Insurance Assistance Program, Department of Economic Security, Division of Aging and Adult Services (DAAS), 1789 W. Jefferson Street, Site Code 950A, Phoenix, AZ 85007

WEBSITE https://des.az.gov/services/older-adults/medicare-assistance

Arkansas

Senior Health Insurance Information Program (SHIIP)

CALL 1-501 371-2782 or 1-800-224-6330

WRITE Senior Health Insurance Information Program (SHIIP), Arkansas Insurance Department, 1200 West Third Street, Little Rock, AR 72201

WEBSITE https://insurance.arkansas.gov/pages/consumer-services/senior-health/

California

Health Insurance Counseling & Advocacy Program (HICAP)

CALL 1-916-419-7500 or 1-800-434-0222

TTY 1-800-735-2929

WRITE Health Insurance Counseling & Advocacy Program (HICAP), California Department of Aging, 1300 National Drive, Suite 200, Sacramento, CA 95834-1992

WEBSITE https://cahealthadvocates.org/hicap/

Colorado

Senior Health Insurance Assistance Program

CALL 1-303-894-7855 or 1-888-696-7213

TTY 1-303-894-7880

WRITE Senior Health Insurance Assistance Program, Department of Regulatory Agencies, Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202

WEBSITE https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare

Connecticut

CHOICES

CALL 1-800-994-9422 or 1-860-424-5274

TTY 1-800-842-4524

WRITE CHOICES, Department of Social Services, Aging Services Division, 25 Sigourney Street, 10th Floor, Hartford, CT 06106

WEBSITE www.ct.gov/agingservices/cwp/view.asp?a=2511&q=313032

Delaware

Delaware Medicare Assistance Bureau (DMAB)

CALL 1-302-674-7364 or 1-800-336-9500

WRITE Delaware Medicare Assistance Bureau (DMAB), 841 Silver Lake Boulevard, Dover, DE 19904

WEBSITE http://insurance.delaware.gov/divisions/dmab/

District of Columbia

Health Insurance Counseling Project (HICP)

CALL 1-202-727-8370

TTY 711.0

WRITE Health Insurance Counseling Project (HICP), 500 K Street, NE Washington, DC 20002

WEBSITE https://dcoa.dc.gov/service/dc-state-health-insurance-assistance-program-ship

Florida

SHINE (Serving Health Insurance Needs of Elders)

CALL 1-800-963-5337

TTY 1-800-955-8771

WRITE SHINE, Department of Elder Affairs, 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000

WEBSITE www.floridashine.org

Georgia

GeorgiaCares

CALL 1-866-552-4464 (option #4)

TTY 1-404-657-1929

WRITE GeorgiaCares, 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303

WEBSITE www.mygeorgiacares.org/

Hawaii

Hawaii SHIP

CALL 1-808 586-7299 or 1-888-875-9229

TTY 1-866-810-4379

WRITE Hawaii SHIP, State Health Insurance Assistance Program, Executive Office on Aging, No. 1 Capitol District, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831

WEBSITE www.hawaiiship.org/

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)

CALL 1-800-247-4422

WRITE Senior Health Insurance Benefits Advisors (SHIBA), Department of Insurance, 700 West State Street, 3rd Floor, P.O. Box 83720, Boise, ID 83720-0043

WEBSITE https://doi.idaho.gov/SHIBA/

Illinois

Senior Health Insurance Program (SHIP)

CALL 1-800-252-8966

TTY 1-888-206-1327

WRITE Senior Health Insurance Program (SHIP), Illinois Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702

WEBSITE https://www2.illinois.gov/aging/ship/Pages/default.aspx

Indiana

State Health Insurance Assistance Program (SHIP)

CALL 1-800-452-4800

TTY 1-866-846-0139

WRITE State Health Insurance Assistance Program (SHIP), Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, IN 42604-2787

WEBSITE www.medicare.in.gov

Iowa

Senior Health Insurance Information Program (SHIIP)

CALL 1-800-351-4664

TTY 1-800-735-2942

WRITE Senior Health Insurance Information Program (SHIIP), 601 Locust St., 4th Floor, Des Moines, IA 50309-3738

WEBSITE https://shiip.iowa.gov/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)

CALL 1-800-860-5260

TTY 1-785-291-3167

WRITE Senior Health Insurance Counseling for Kansas (SHICK), Kansas Department for Aging and Disability Services, New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404

WEBSITE www.kdads.ks.gov/SHICK/shick_index.html

Kentucky

State Health Insurance Assistance Program

CALL 1-877-293-7447 (option 2)

TTY 1-800-648-6056

WRITE State Health Insurance Assistance Program, Cabinet for Health and Family Services, Office of the Secretary, 275 East Main Street, Frankfort, KY 40621

WEBSITE https://chfs.ky.gov/agencies/dail/Pages/ship.aspx

Louisiana

Senior Health Insurance Information Program (SHIIP)

CALL 1-225-342-5301 or 1-800-259-5300

WRITE Senior Health Insurance Information Program (SHIIP), Louisiana Department of Insurance, 1702 N. Third Street, P.O. Box 94214, Baton Rouge, LA 70802

WEBSITE www.ldi.la.gov/SHIIP/

Maine

Maine State Health Insurance Program (SHIP)

CALL 1-800-262-2232

TTY 711.0

WRITE Maine State Health Insurance Program (SHIP), OADS Aging Services, Maine Department of Health and Human Services, 11 State House Station, Augusta, ME 04333

WEBSITE www.maine.gov/dhhs/oads/community-support/ship.html

Maryland

Senior Health Insurance Assistance Program

CALL 1-410-767-1100 or 1-800-243-3425

TTY 711.0

WRITE Senior Health Insurance Assistance Program, Maryland Department of Aging, 301 West Preston Street, Suite 1007, Baltimore, MD 21201

WEBSITE https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Massachusetts

Serving the Health Insurance Needs of Everyone (SHINE)

CALL 1-800-243-4636

TTY 711.0

WRITE Serving the Health Insurance Needs of Everyone (SHINE), Executive Office of Elder Affairs, One Ashburton Place, Fifth Floor, Boston, MA 02108

WEBSITE www.mass.gov/elders/healthcare/shine/

Michigan

Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.)

CALL 1-800-803-7174

WRITE Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.), 6105 West St. Joseph, Suite 204, Lansing, MI 48917-4850

WEBSITE www.mmapinc.org/

Minnesota

Minnesota State Health Insurance Assistance

CALL 1-800-333-2433

TTY 1-800-627-3529

WRITE Minnesota State Health Insurance Assistance Program/Senior LinkAge Line, Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164-0976

WEBSITE http://www.mnaging.org/Advisor/SLL/ SLL_SHIP.aspx

Mississippi

State Health Insurance Assistance Program (SHIP)

CALL 1-601-359-4500

WRITE State Health Insurance Assistance Program (SHIP), Mississippi Department of Human Services, Division of Aging & Adult Services, 750 North State Street, Jackson, MS 39202

WEBSITE http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

Missouri

CLAIM - State Health Insurance Assistance Program

CALL 1-800-390-3330

WRITE CLAIM - State Health Insurance Assistance Program, c/o Primaris, 200 N. Keene Street, Suite 101, Columbia, MO 65201

WEBSITE www.missouriclaim.org

Montana

Montana State Health Insurance Assistance Program (SHIP)

CALL 1-800-551-3191

WRITE Montana State Health Insurance Assistance Program (SHIP), Department of Public Health & Human Services, Senior and Long Term Care Division, 2030 11th Avenue, Helena, MT 59601

WEBSITE https://dphhs.mt.gov/sltc/aging/ship

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)

CALL 1-402-471-2201 or 1-800-234-7119

TTY 1-800-833-7352

WRITE Nebraska Senior Health Insurance Information Program (SHIIP), Nebraska Department of Insurance, Terminal Building, 941 O Street, Suite 400, P.O. Box 82089, Lincoln, NE 68508

WEBSITE https://doi.nebraska.gov/consumer/senior-health

Nevada

State Health Insurance Assistance Program

CALL 1-702-486-3478 or 1-800-307-4444

WRITE State Health Insurance Assistance Program, Nevada Aging and Disability Services Division, 3416 Goni Road, Suite D-132, Carson City, NV 89706

WEBSITE http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/

New Hampshire

ServiceLink Aging & Disability Resource Center

CALL 1-866-634-9412

TTY 1-800-735-2964

WRITE ServiceLink Aging & Disability Resource Center, Bureau of Elderly & Adult Services, Division of Community Based Care Services, NH Department of Health & Human Services, 129 Pleasant Street, Concord, NH 03301

WEBSITE www.nh.gov/servicelink/

New Jersey

State Health Insurance Assistance Program (SHIP)

CALL 1-800-792-8820

WRITE State Health Insurance Assistance Program (SHIP), Division of Aging Services, P.O. Box 715, Mercerville, NJ 08625-0715

WEBSITE www.state.nj.us/humanservices/doas/services/ship/index.html

New Mexico

Aging & Disability Resource Center (ADRC)

CALL 1-800-432-2080

TTY 1-505-476-4937

WRITE Aging & Disability Resource Center (ADRC), New Mexico Aging & Long-Term Services Department, 2550 Cerrillos Road, Santa Fe, NM 87505

WEBSITE www.nmaging.state.nm.us

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)

CALL 1-800-701-0501

WRITE Health Insurance Information Counseling and Assistance Program (HIICAP), New York State Office for the Aging, 2 Empire State Plaza, Albany, NY 12223-1251

WEBSITE https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

North Carolina

Seniors' Health Insurance Information Program (SHIIP)

CALL 1-855-408-1212

WRITE Seniors' Health Insurance Information Program (SHIIP), 1201 Mail Service Center, Raleigh, NC 27699-1201

WEBSITE www.ncdoi.com/SHIIP/Default.aspx

North Dakota

State Health Insurance Counseling Program (SHIC)

CALL 1-701 328-2440 or 1-888-575-6611

TTY 1-800-366-6888

WRITE State Health Insurance Counseling Program (SHIC), North Dakota Insurance Department, 600 East Boulevard Avenue, Bismarck, ND 58505-0320

WEBSITE www.nd.gov/ndins/shic/

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)

CALL 1-800-686-1578

TTY 1-614-644-3745

WRITE Ohio Senior Health Insurance Information Program (OSHIIP), The Ohio Department of Insurance, 50 W. Town Street, 3rd Floor, Suite 300, Columbus, OH 43215

WEBSITE https://insurance.ohio.gov/consumers/medicare/medicare-counseling-webinars

Oklahoma

Senior Health Insurance Counseling Program (SHIP)

CALL 1-405-521-6628 or 1-800-763-2828

WRITE Senior Health Insurance Counseling Program (SHIP), Five Corporate Plaza, 3625 NW 56th Street, Suite 100, Oklahoma City, OK 73112

WEBSITE http://www.okdrs.org/guide/senior-health-insurance-counseling-program-ship

Oregon

Senior Health Insurance Benefits Assistance Program (SHIBA)

CALL 1-800-722-4134

TTY 1-800-735-2900

WRITE Senior Health Insurance Benefits Assistance Program (SHIBA), P.O. Box 14480, Salem, OR 97309

WEBSITE https://healthcare.oregon.gov/shiba/pages/index.aspx

Pennsylvania

APPRISE

CALL 1-800-783-7067

WRITE APPRISE, Commonwealth of Pennsylvania Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919

WEBSITE www.aging.pa.gov

Puerto Rico

Office for the Elderly

CALL 1-787-721-6121

WRITE Office for the Elderly, PO Box 191170, San Juan, PR 00919-1179

Rhode Island

Senior Health Insurance Program (SHIP)

CALL 1-401-462-3000 or 1-401-462-0510

TTY 1-401-462-0740

WRITE Senior Health Insurance Program (SHIP), Rhode Island Department of Human Services, Division of Elderly Affairs, 74 West Road, Hazard Building, 2nd Floor, Cranston, RI 02920

WEBSITE http://oha.ri.gov/what-we-do/access/health-insurance-coaching/ship/

South Carolina

Insurance Counseling Assistance and Referrals for Elders Program (I-CARE)

CALL 1-803 734-9900 or 1-800-868-9095

WRITE Insurance Counseling Assistance and Referrals for Elders Program (I-CARE), The Lieutenant Governor’s Office on Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201

WEBSITE https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud

South Dakota

Senior Health Information & Insurance Education (SHIINE)

CALL 1-800-536-8197

WRITE Senior Health Information & Insurance Education (SHIINE), South Dakota Department of Social Services, 700 Governors Drive, Pierre, SD 57501

WEBSITE www.shiine.net/

Tennessee

Tennessee State Health Insurance Assistance Program (SHIP)

CALL 1-877-801-0044

WRITE Tennessee State Health Insurance Assistance Program (SHIP), Tennessee Commission on Aging and Disability, 500 Deaderick Street, Suite 825, Nashville, TN 37243-0201

WEBSITE https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html

Texas

Texas Health Information Counseling & Advocacy Program (HICAP)

CALL 1-800-252-9240

TTY 711.0

WRITE Texas Health Information Counseling & Advocacy Program (HICAP), Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104

WEBSITE https://hhs.texas.gov/services/health/medicare

Utah

State Health Insurance Assistance Program (SHIP)

CALL 1-800-541-7735

WRITE State Health Insurance Assistance Program (SHIP), Utah Department of Human Services, Division of Aging and Adult Services, 195 North 1950 West, Salt Lake City, UT 84116

WEBSITE https://daas.utah.gov/seniors/#shiip

Vermont

Vermont State Health Insurance Assistance Program (SHIP)

CALL 1-800-642-5119

WRITE Vermont Association of Area Agencies, Vermont State Health Insurance Assistance Program (SHIP), 476 Main Street, Suite 3, Winooski, VT 05404

WEBSITE https://www.vermont4a.org/

Virginia

Virginia Insurance Counseling & Assistance Program (VICAP)

CALL 1-804 662-9333 or 1-800-552-3402

TTY 711.0

WRITE Virginia Insurance Counseling & Assistance Program (VICAP), The Office for Aging Services of the Division for Community Living, 1610 Forest Avenue, Suite 100, Henrico, VA 23229

WEBSITE https://www.vda.virginia.gov/vicap.htm

Washington

Statewide Health Insurance Benefits Advisors (SHIBA)

CALL 1-800-562-6900

TTY 1-360-586-0241

WRITE Statewide Health Insurance Benefits Advisors (SHIBA), Office of the Insurance Commissioner, P.O. Box 40256, Olympia, WA 98504-0256

WEBSITE www.insurance.wa.gov/shiba

West Virginia

West Virginia SHIP

CALL 1-304-558-3317 or 1-877-987-4463

WRITE West Virginia SHIP, 1900 Kanawha Boulevard East, Charleston, WV 25305

WEBSITE www.wvship.org/

Wisconsin

State Health Insurance Assistance Program (SHIP)

CALL 1-800-242-1060

TTY 1-262-347-3045

WRITE State Health Insurance Assistance Program (SHIP), Wisconsin Department of Health Services, 1 West Wilson Street, Madison, WI 53703

WEBSITE https://www.dhs.wisconsin.gov/benefit-specialists/ebs.htm

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)

CALL 1-800-856-4398

WRITE Wyoming State Health Insurance InformationProgram (WSHIIP), 106 West Adams Avenue, Riverton, WY 82501

WEBSITE www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

Appendix B: Quality Improvement Organizations (QIO) contact information

Alabama

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Alaska

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Arizona

Livanta

CALL	1-877-588-1123
TTY	1-855-887-6668
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Arkansas

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

California

Livanta

CALL	1-877-588-1123
TTY	1-855-887-6668
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Colorado

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Connecticut

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Delaware

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

District of Columbia

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Florida

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Georgia

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Hawaii

Livanta

CALL	1-877-588-1123
TTY	1-855-887-6668
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Idaho

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Illinois

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Indiana

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Iowa

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Kansas

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Kentucky

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Louisiana

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Maine

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Maryland

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Massachusetts

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Michigan

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Minnesota

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Mississippi

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Missouri

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Montana

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Nebraska

Livanta

CALL	1-888-755-5580
TTY	1-888-985-9295
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Nevada

Livanta

CALL	1-877-588-1123
TTY	1-855-887-6668
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

New Hampshire

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

New Jersey

Livanta

CALL	1-866-815-5440
TTY	1-866-868-2289
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

New Mexico

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

New York

Livanta

CALL	1-866-815-5440
TTY	1-866-868-2289
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

North Carolina

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

North Dakota

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Ohio

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Oklahoma

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Oregon

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Pennsylvania

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Rhode Island

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

South Carolina

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

South Dakota

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Tennessee

KEPRO

CALL	1-888-317-0751
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Texas

KEPRO

CALL	1-888-315-0636
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

Utah

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Vermont

KEPRO

CALL	1-888-319-8452
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Virginia

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Washington

KEPRO

CALL	1-888-305-6759
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

West Virginia

Livanta

CALL	1-888-396-4646
TTY	1-888-985-2660
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Wisconsin

Livanta

CALL	1-888-524-9900
TTY	1-888-985-8775
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Wyoming

KEPRO

CALL	1-888-317-0891
TTY	1-855-843-4776
HOURS	Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.
WRITE	KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
WEBSITE	www.keproqio.com

Appendix C: State Medicaid Agencies contact information

Alabama

Alabama Medicaid Agency

CALL 1-334-242-5000 or 1-800-362-1504

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Alabama Medicaid Agency, P.O. Box 5624, Montgomery, AL 36103-5624

WEBSITE www.medicaid.alabama.gov

Alaska

State of Alaska Department of Health & Social Services

CALL 1-800-770-5650, opción 2

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE State of Alaska Department of Health & Social Services, Division of Health Care Services, 4501 Business Park Blvd., Bldg. L, Anchorage, AK 99503-2400

WEBSITE http://dhss.alaska.gov

Arizona

Arizona Health Care Cost Containment System (AHCCCS)

CALL 1-602-417-4000 or 1-800-523-0231

HOURS Monday – Friday, 7:00 a.m. – 9:00 p.m.; Saturday, 8:00 a.m. – 6:00 p.m.

WRITE Arizona Health Care Cost Containment System (AHCCCS), 801 E. Jefferson Street, Phoenix, AZ 85034

WEBSITE https://www.azahcccs.gov

Arkansas

Arkansas Medicaid

CALL 1-800-482-8988

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Arkansas Medicaid, Arkansas Division of Medical Services, Department of Human Services, Donaghey Plaza South, P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437

WEBSITE https://www.benefits.gov/benefit/1089

California

Medi-Cal

CALL 1-916 552-9200 or 1-800-541-5555

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Medi-Cal, P.O. Box 997417, MS 4607, Sacramento, CA 95899-7417

WEBSITE www.dhcs.ca.gov

Colorado

Health First Colorado

CALL 1-303 866-2993 or 1-800-221-3943

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Health First Colorado, Department of Health Care Policy & Financing, 1570 Grant Street, Denver, CO 80203

WEBSITE https://www.healthfirstcolorado.com/

Connecticut

Connecticut Department of Social Services

CALL 1-855-626-6632

TTY 1-800-842-4524

HOURS Monday – Friday, 7:30 a.m. – 4:00 p.m.

WRITE Connecticut Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033

WEBSITE www.ct.gov/dss

Delaware

Delaware Health & Social Services

CALL 1-302-255-9500 or 1-800-372-2022

HOURS Monday – Friday, 7:30 a.m. – 4:30 p.m.

WRITE Delaware Health & Social Services, Division of Medicaid and Medical Assistance, Lewis Building, Herman Holloway Sr. Campus, 1901 N. DuPont Highway, New Castle, DE 19720

WEBSITE www.dhss.delaware.gov/dhss/dmma/

District of Columbia

Department of Health Care Finance

CALL 1-202-442-5988

TTY 711.0

HOURS Monday – Friday, 8:15 a.m. – 4:45 p.m.

WRITE Department of Health Care Finance, 441 4th Street, NW, 900S, Washington, DC 20001

WEBSITE http://dhcf.dc.gov/

Florida

Agency For Health Care Administration

CALL 1-877-711-3662

TTY 1-866-467-4970

HOURS Monday – Thursday, 8:00 a.m. – 8:00 p.m., Friday, 8:00 a.m. – 7:00 p.m.

WRITE Agency For Health Care Administration, P.O. Box 5197, Tallahassee, FL 32314

WEBSITE http://www.flmedicaidmanagedcare.com/

Georgia

Georgia Department of Community Health

CALL 1-404-657-5468

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Georgia Department of Community Health, 2 Peachtree Street, NW, Atlanta, GA 30303

WEBSITE https://medicaid.georgia.gov

Hawaii

Department of Human Services

CALL 1-800-316-8005

TTY 1-800-603-1201

HOURS Monday – Friday, 7:45 a.m. – 4:30 p.m.

WRITE Department of Human Services, Med-QUEST Division, P.O. Box 700190, Kapolei, HI 96709-0190

WEBSITE http://humanservices.hawaii.gov/

Idaho

Idaho Department of Health and Welfare

CALL 1-877 456-1233 or 1-800-926-2588

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Idaho Department of Health and Welfare, 450 W State Street, Boise, ID 83702

WEBSITE http://www.healthandwelfare.idaho.gov/Medical/ Medicaid/tabid/123/Default.aspx

Illinois

Illinois Department of Healthcare and Family Services

CALL 1-800-843-6154

TTY 1-800-447-6404

HOURS Monday – Friday, 8:00 a.m. – 4:45 p.m.

WRITE Illinois Department of Healthcare and Family Services, 401 South Clinton, Chicago, IL 60607

WEBSITE www.illinois.gov/hfs/Pages/default.aspx

Indiana

Indiana Medicaid

CALL 1-317 713-9627 or 1-800-457-4584

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Indiana Family & Social Services Administration, Division of Family Resources, Office of Medicaid Policy and Planning, 402 W. Washington Street, Room W382, Indianapolis, IN 46204-2739

WEBSITE http://www.in.gov/medicaid/members/

Iowa

Iowa Medicaid Enterprise

CALL 1-515-256-4606 or 1-800-338-8366
TTY 1-800-735-2942
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Iowa Medicaid Enterprise, Customer Service, P.O. Box 36510, Des Moines, IA 50315
WEBSITE http://dhs.iowa.gov/iahealthlink

Kansas

KanCare

CALL 1-800-792-4884
TTY 1-800-792-4292
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE KanCare, P.O. Box 3599, Topeka, KS 66601-9738
WEBSITE www.kancare.ks.gov/

Kentucky

Cabinet for Health and Family Services

CALL 1-855-306-8959
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Cabinet for Health and Family Services, Department for Medicaid Services, 275 East Main Street, Frankfort, KY 40621
WEBSITE https://chfs.ky.gov/agencies/dms/member/Pages/default.aspx

Louisiana

Louisiana Medicaid

CALL 1-888-342-6207
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Louisiana Medicaid, Department of Health and Hospitals, P.O. Box 629, Baton Rouge, LA 70821-0629
WEBSITE www.dhh.louisiana.gov

Maine

Office of MaineCare Services

CALL 1-855-797-4357
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Office of MaineCare Services, 11 State House Station, Augusta, ME 04333-0011
WEBSITE http://www.maine.gov/dhhs/oms/

Maryland

Maryland Department of Health & Mental Hygiene

CALL 1-410-767-6500 or 1-800-492-5231
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Medicaid/Medical Assistance, Maryland Department of Health & Mental Hygiene, 201 West Preston Street, Baltimore, MD 21201
WEBSITE https://health.maryland.gov/mmcp/pages/home.aspx

Massachusetts

Office of Medicaid

CALL 1-617-573-1770 or 1-800-841-2900
TTY 1-800-497-4648
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Office of Medicaid, One Ashburton Place, 11th Floor, Boston, MA 02108
WEBSITE www.mass.gov/masshealth

Michigan

Michigan Department of Health & Human Services

CALL 1-517-373-3740 or 1-800-642-3195
TTY 1-800-649-3777
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Michigan Department of Health & Human Services, 333 S. Grand Avenue, P.O. Box 30195, Lansing MI 48909
WEBSITE www.michigan.gov/mdhhs

Minnesota

Minnesota Department of Human Services

CALL 1-651-431-2670 or 1-800-657-3739
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE Medical Assistance (MA), Minnesota Department of Human Services, P.O. Box 64989, St. Paul, MN 55164
WEBSITE http://mn.gov/dhs/

Mississippi

Mississippi Division of Medicaid

CALL 1-601-359-6050 or 1-800-421-2408
HOURS Monday – Friday, 7:30 a.m. – 5:00 p.m.
WRITE Mississippi Division of Medicaid, Sillers Building, 550 High Street, Suite 1000, Jackson, MS 39201-1399
WEBSITE www.medicaid.ms.gov

Missouri

MO HealthNet Division

CALL 1-573-751-3425 or 1-800-392-2161
TTY 1-800-735-2966
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE The State of Missouri, MO HealthNet Division, 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-6500
WEBSITE http://dss.mo.gov/mhd

Montana

Department of Public Health & Human Services

CALL 1-406-444-4455 or 1-800-362-8312
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Department of Public Health & Human Services, Health Resources Division, P. O. Box 202951, Helena, MT 59620-2951
WEBSITE www.dphhs.mt.gov/

Nebraska

Nebraska Department of Health and Human Services

CALL 1-855-632-7633
TTY 1-402-471-7256
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care, P.O. Box 95026, Lincoln, NE 68509-5026
WEBSITE http://dhhs.ne.gov

Nevada

Nevada Department of Health and Human Services

CALL 1-877-638-3472
HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m.
WRITE Nevada Department of Health and Human Services, Division of Health Care Financing and Policy, 1100 E. William Street, Suite 111, Carson City, NV 89701
WEBSITE https://dwss.nv.gov/

New Hampshire

NH Department of Health and Human Services

CALL 1-603-271-4344 or 1-844-275-3447
TTY 1-800-735-2964
HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE Office of Medicaid Business & Policy, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301
WEBSITE https://www.dhhs.nh.gov/

New Jersey

NJ Department of Human Services

CALL 1-800-356-1561
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE NJ Department of Human Services, Division of Medical Assistance and Health Services, P.O. Box 712, Trenton, NJ 08625-0712
WEBSITE www.state.nj.us/humanservices/dmahs

New Mexico

NM Human Services Department's Medical Assistance Division

CALL 1-505-827-3100 or 1-888-997-2583
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE NM Human Services Department's Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504-2348
WEBSITE https://nmmedicaid.portal.conduent.com/static/index.htm

New York

New York State Department of Health

CALL 1-800-541-2831
HOURS Monday – Friday, 8:00 a.m. – 4:45 p.m.
WRITE New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237
WEBSITE www.health.ny.gov/health_care/medicaid/

North Carolina

NC Division of Medical Assistance

CALL 1-919-855-4100 or 1-800-662-7030
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE NC Division of Medical Assistance, 2501 Mail Service Center, Raleigh, NC 27699-2501
WEBSITE https://medicaid.ncdhhs.gov/

North Dakota

North Dakota Department of Human Services

CALL 1-701-328-7068 or 1-800-755-2604
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Medical Services Division, North Dakota Department of Human Services, 600 E. Boulevard Avenue, Dept 325, Bismarck, ND 58505-0250
WEBSITE www.nd.gov/dhs/

Ohio

Ohio Department of Medicaid

CALL 1-800-324-8680
TTY 1-800-292-3572
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m., Saturday – Sunday, 8:00 a.m. – 5:00 p.m.
WRITE Ohio Department of Medicaid, 50 West Town Street, Suite 400, Columbus, OH 43215
WEBSITE http://medicaid.ohio.gov/

Oklahoma

Oklahoma Health Care Authority

CALL 1-405-522-7300 or 1-800-987-7767
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:30 p.m.
WRITE Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105
WEBSITE https://oklahoma.gov/ohca.html

Oregon

Oregon Health Plan

CALL 1-800-699-9075 or 1-800-273-0557
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Oregon Health Plan, Health Systems Division, 500 Summer Street NE, Salem, OR 97301-1079
WEBSITE www.oregon.gov/OHA/healthplan/

Pennsylvania

Pennsylvania Department of Human Services

CALL 1-800-692-7462
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 4:45 p.m.
WRITE Pennsylvania Department of Human Services, Office of Medical Assistance Programs, P.O. Box 2675, Harrisburg, PA 17105-2675
WEBSITE http://www.dhs.pa.gov/

Puerto Rico

Medicaid Program Dept of Health

CALL (787) 765-2929 Ext. 6700

WRITE Medicaid Program Department of Health, P.O. Box 70184 San Juan, PR 00936-8184

Rhode Island

Rhode Island Department of Human Services

CALL 1-855-697-4347

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:00 p.m.

WRITE Rhode Island Department of Human Services, Louis Pasteur Building, 600 New London Avenue, Cranston, RI 02921

WEBSITE www.dhs.ri.gov

South Carolina

South Carolina Health Connections Medicaid

CALL 1-888-549-0820

TTY 1-888-842-3620

HOURS Monday – Friday, 8:00 a.m. – 6:00 p.m., Saturday, 9:00 a.m. – 12:00 p.m.

WRITE Department of Health and Human Services, South Carolina Health Connections Medicaid, P.O. Box 8206, Columbia, SC 29202

WEBSITE www.scdhhs.gov

South Dakota

South Dakota Department of Social Services

CALL 1-605-773-4678 or 1-800-597-1603

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE South Dakota Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, SD 57501

WEBSITE http://dss.sd.gov/medicaid

Tennessee

TennCare

CALL 1-800-342-3145

TTY 1-877-779-3103

HOURS Monday – Friday, 7:00 a.m. – 6:00 p.m.

WRITE TennCare, 310 Great Circle Road, Nashville, TN 37243

WEBSITE www.tn.gov/tenncare/

Texas

Texas Health and Human Services Commission

CALL 1-512-424-6500 or 1-800-252-8263

TTY 1-800-735-2989

HOURS Monday – Friday, 7:30 a.m. – 5:30 p.m.

WRITE Texas Health and Human Services Commission, Brown-Heatly Building, 4900 N. Lamar Boulevard, Austin, TX 78751-2316

WEBSITE https://yourtexasbenefits.hhsc.texas.gov/

Utah

Utah Department of Health

CALL 1-801-538-6155 or 1-800-662-9651

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Utah Department of Health, Division of Medicaid and Health Financing, P.O. Box 143106, Salt Lake City, UT 84114-3106

WEBSITE https://medicaid.utah.gov/

Vermont

Green Mountain Care

CALL 1-800-250-8427

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 8:00 p.m.

WRITE Green Mountain Care, Department of Vermont Health Access, 280 State Dr., Waterbury, VT 05671

WEBSITE www.greenmountaincare.org/

Virginia

Department of Medical Assistance Services

CALL 1-804-786-7933
TTY 1-800-343-0634
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Department of Medical Assistance Services, Attn: Director's Office, 600 East Broad Street, Richmond, VA 23219
WEBSITE https://www.dmas.virginia.gov/

Washington

Washington Apple Health (Medicaid)

CALL 1-800-562-3022
TTY 711.0
HOURS Monday – Friday, 7:00 a.m. – 5:00 p.m.
WRITE Washington Apple Health (Medicaid), P.O. Box 45531, Olympia, WA 98504
WEBSITE http://www.hca.wa.gov/medicaid/Pages/index.aspx

West Virginia

West Virginia Bureau for Medical Services

CALL 1-304-558-1700 or 1-888-483-0797
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE West Virginia Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, WV 25301
WEBSITE www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Department of Health Services

CALL 1-608-266-1865 or 1-800-362-3002
TTY 711.0
HOURS Monday – Friday, 7:45 a.m. – 4:30 p.m.
WRITE Department of Health Services, 1 West Wilson Street, Madison, WI 53703
WEBSITE www.dhs.wisconsin.gov/

Wyoming

Wyoming Medicaid

CALL 1-307-777-7531 or 1-855-294-2127
TTY 1-307-777-5648
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Wyoming Medicaid, 6101 Yellowstone Road, Suite 210, Cheyenne, WY 82009
WEBSITE https://health.wyo.gov/healthcarefin/medicaid/

Appendix D: State Pharmaceutical Assistance Programs (SPAP) contact information

Delaware

Chronic Renal Disease Program (CRDP)

CALL 1-302-424-7180 or 1-800-464-4357
HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE Chronic Renal Disease Program (CRDP), Delaware Health and Social Services (DHSS), 13 S.W. Front Street, Milford, DE 19963
WEBSITE www.dhss.delaware.gov/dhss/dmma/crdprog.html

Delaware

Delaware Prescription Assistance Program

CALL 1-800-996-9969
HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE DPAP, P.O. Box 950, New Castle, DE 19720
WEBSITE https://dhss.delaware.gov/dhss/dmma/dpap.html

Indiana

HoosierRx

CALL 1-866-267-4679
HOURS Monday – Friday, 7:00 a.m. – 3:00 p.m.
WRITE HoosierRx, P.O. Box 6224, Indianapolis, IN 46206
WEBSITE https://www.in.gov/medicaid/members/194.htm

Maine

Maine DEL

CALL 1-866-796-2463
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE Office for Family Independence, State of Maine-- DHHS, 114 Corn Shop Lane, Farmington, ME 04938-9900
WEBSITE https://www.mainecahc.org/guide-to-maine-health- care/other-helpful-programs/help-paying-for- prescriptions/#DEL

Massachusetts

Prescription Advantage

CALL 1-800-243-4636
TTY 1-877-610-0241
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Prescription Advantage, P.O. Box 15153, Worcester, MA 01615-0153
WEBSITE https://www.mass.gov/prescription-drug-assistance

Maryland

Maryland - SPDAP

CALL 1-800-551-5995
TTY 1-800-877-5156
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Maryland - SPDAP, c/o Pool Administrators, 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033
WEBSITE http://marylandspdap.com

Maryland

Maryland Kidney Disease Program

CALL 1-410 767-5000 or 1-800-226-2142
HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.
WRITE Maryland Kidney Disease Program, 201 W. Preston Street, Room SS-3, Baltimore, MD 21201
WEBSITE www.mdrxprograms.com/kdp.html

Montana

Big Sky Rx Program

CALL 1-866-369-1233
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Big Sky Rx Program, P.O. Box 202915, Helena, MT 59620-2915
WEBSITE https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky

Montana

Montana Mental Health Services Plan (MHSP)

CALL 1-406-443-7871

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Montana Mental Health Services Plan (MHSP), 555 Fuller Ave., P.O. Box 202905, Helena, MT 59620-2905

WEBSITE Mental Health Services Plan (MHSP) Public Mental Health Services for Adults (mt.gov)

Nevada

Nevada Senior Rx

CALL 1-866-303-6323 (option 2)

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Nevada Senior Rx, 1860 E. Sahara Avenue, Las Vegas, NV 89104

WEBSITE http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

New Jersey

Pharmaceutical Assistance to the Aged and Disabled (PAAD)

CALL 1-800-792-9745

HOURS 24 hours, 7 days a week automated system

WRITE Pharmaceutical Assistance to the Aged and Disabled (PAAD), Department of Human Services, P.O. Box 715, Trenton, NJ 08625-0715

WEBSITE http://www.state.nj.us/humanservices/doas/services/paad/

New York

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

CALL 1-800-332-3742

TTY 1-800-290-9138

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE EPIC, P.O. Box 15018, Albany, NY 12212-5018

WEBSITE www.health.ny.gov/health_care/epic/

Oklahoma

Rx for Oklahoma Prescription Assistance

CALL 1-877-794-6552

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Rx for Oklahoma Prescription Assistance, Oklahoma Department of Commerce, 900 N. Stiles Ave., Oklahoma City, OK 73104

WEBSITE https://www.oid.ok.gov/consumers/information-for- seniors/senior-health-insurance-counseling- program-ship/low-income-subsidy-lis-for- prescription-drugs/

Pennsylvania

Pharmaceutical Assistance Contract for the Elderly (PACE)

CALL 1-717 651-3600 or 1-800-225-7223

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Pharmaceutical Assistance Contract for the Elderly (PACE), P.O. Box 8806, Harrisburg, PA 17105

WEBSITE http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Pennsylvania

PACE Needs Enhancement Tier (PACENET)

CALL 1-717 651-3600 or 1-800-225-7223

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE PACE Needs Enhancement Tier (PACENET), P.O. Box 8806, Harrisburg, PA 17105

WEBSITE http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Pennsylvania

Special Pharmaceutical Benefits Program-Mental Health

CALL 1-800-433-4459

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Special Pharmaceutical Benefits Program-Mental Health, Department of Human Servcies OMHSAS, Commonwealth Tower 12th Floor, P.O. Box 2675, Harrisburg, PA 17105-2675

WEBSITE https://www.dhs.pa.gov/about/Pages/DHS-Sites.aspx

Pennsylvania

Chronic Renal Disease Program (CRDP)

CALL 1-800-225-7223

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE The Chronic Renal Disease Program, Pennsylvania Department of Health, Division of Child and Adult Health Services, 625 Forster St., 7th Floor East Wing, Harrisburg, PA 17120-0701

WEBSITE http://www.health.pa.gov/

Rhode Island

Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)

CALL 1-401-462-3000

TTY 1-401-462-0740

HOURS Monday – Friday, 8:30 a.m. – 4:00 p.m.

WRITE Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE), 57 Howard Avenue, Louis Pasteur Building, Cranston, RI 02920

WEBSITE http://oha.ri.gov/

Texas

Kidney Health Care Program

CALL 1-512-776-7150 or 1-800-222-3986

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Kidney Health Care Program, Specialty Health Care Services, MC 1938, P.O. Box 149347, Austin, TX 78714

WEBSITE https://hhs.texas.gov/services/health/kidney-health-care

Vermont

Green Mountain Care, VPharm

CALL 1-800-250-8427

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Green Mountain Care, VPharm, Health Access Customer Service, Department of Vermont Health Access, 312 Hurricane Lane, Williston, VT 05495

WEBSITE http://www.greenmountaincare.org/prescription

Wisconsin

SeniorCare

CALL 1-800-657-2038

HOURS Monday – Friday, 8:00 a.m. – 6:00 p.m.

WRITE SeniorCare, P.O. Box 6710, Madison, WI 53716-0710

WEBSITE www.dhs.wisconsin.gov/seniorcare/

Wisconsin

Wisconsin Chronic Renal Disease Program

CALL 1-800-362-3002

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE Wisconsin Chronic Renal Disease Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410

WEBSITE https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Hemophilia Home Care Program

CALL	1-800-362-3002
HOURS	Monday – Friday, 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Hemophilia Home Care Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Adult Cystic Fibrosis Program

CALL	1-800-362-3002
HOURS	Monday – Friday, 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Adult Cystic Fibrosis Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Appendix E: AIDS Drug Assistance Programs (ADAP) contact information

Alabama

Alabama AIDS Drug Assistance Program

CALL 1-866-574-9964

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Alabama AIDS Drug Assistance Program, HIV/ AIDS Division, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104

WEBSITE http://www.alabamapublichealth.gov/hiv/adap.html

Alaska

Alaskan AIDS Assistance Association

CALL 1-907-263-2050 or 1-800-478-2437

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Alaskan AIDS Assistance Program, 1057 W. Fireweed Lane, Anchorage, AK 99503

WEBSITE http://www.alaskanaids.org/index.php/client-services/adap

Arizona

Arizona AIDS Drug Assistance Program

CALL 1-602-364-3610 or 1-800-334-1540

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Arizona AIDS Drug Assistance Program, Arizona Department of Health, 150 North 18th Avenue, Suite 130, Phoenix, AZ 85007

WEBSITE http://www.azdhs.gov/phs/hiv/adap/

Arkansas

Arkansas AIDS Drug Assistance Program

CALL 1-501-661-2408 or 1-888-499-6544

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Arkansas AIDS Drug Assistance Program, Arkansas Department of Health, 4815 W. Markham, Little Rock, AR 72205

WEBSITE http://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program

California

California AIDS Drug Assistance Program

CALL 1-844-421-7050

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE California AIDS Drug Assistance Program, CDPH, P.O. Box 997426, Mail Stop 7704, Sacramento, CA 95899

WEBSITE https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx

Colorado

Bridging the Gap, Colorado

CALL 1-303-692-2783

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Bridging the Gap, Colorado-3835, 4300 Cherry Creek Dr. South, Denver, CO 80246-1530

WEBSITE https://cdphe.colorado.gov/state-drug-assistance-program

Connecticut

Connecticut AIDS Drug Assistance Program

CALL 1-860-509-7806 or 1-800-233-2503

HOURS Monday – Friday, 7:30 a.m. – 4:00 p.m.

WRITE Connecticut AIDS Drug Assistance Program, Connecticut Department of Public Health, 410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134

WEBSITE http://www.ct.gov/dph/cwp/view.asp?a=3135&Q=387012

Delaware

Delaware AIDS Drug Assistance Program

CALL 1-302-744-1050

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Delaware AIDS Drug Assistance Program, Delaware Health & Social Services, Division of Public Health, Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901

WEBSITE http://dhss.delaware.gov/dph/dpc/hivtreatment.html

District of Columbia

DC AIDS Drug Assistance Program

CALL 1-202-671-4900

TTY 711.0

HOURS Monday – Friday, 8:15 a.m. – 4:45 p.m.

WRITE DC AIDS Drug Assistance Program, District of Columbia Department of Health, 899 North Capitol Street NE, Washington, DC 20002

WEBSITE https://dchealth.dc.gov/DC-ADAP

Florida

Florida AIDS Drug Assistance Program

CALL 1-850-245-4422 or 1-800-352-2437

TTY 1-888-503-7118

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Florida AIDS Drug Assistance Program, Florida Department of Health, Section of HIV/AIDS and Hepatitis, AIDS Drug Assistance Program, 4052 Bald Cypress Way, BIN A09, Tallahassee, FL 32399

WEBSITE http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html

Georgia

Georgia AIDS Assistance Program

CALL 1-404-463-0416

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m.

WRITE Georgia AIDS Assistance Program, Georgia Department of Public Health, 2 Peachtree Street NW, 15th Floor, Atlanta, GA 30303-3186

WEBSITE http://dph.georgia.gov/adap-program

Hawaii

Hawaii AIDS Drug Assistance Program

CALL 1-808-733-9360

HOURS Monday – Friday, 7:45 a.m. – 4:30 p.m.

WRITE Hawaii AIDS Drug Assistance Program, Hawaii Department of Health, Harm Reduction Services Branch, 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816

WEBSITE https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/

Idaho

Idaho AIDS Drug Assistance Program

CALL 1-208-334-5612 or 1-800-926-2588

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Idaho AIDS Drug Assistance Program, Ryan White Part B Program, 450 W. State Street, P.O. Box 83720 Boise, ID 83720-0036

WEBSITE http://www.healthandwelfare.idaho.gov/Health/ FamilyPlanning,STDHIV/HIVCareandTreatment/tabid/391/Default.aspx

Illinois

Illinois AIDS Drug Assistance Program

CALL 1-217-782-4977 or 1-800-825-3518

TTY 1-800-547-0466

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Illinois AIDS Drug Assistance Program, Illinois Department of Public Health, Illinois ADAP Office, 525 West Jefferson Street, Springfield, IL 62761

WEBSITE https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services

Indiana

Indiana AIDS Drug Assistance Program

CALL 1-866-588-4948

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Indiana AIDS Drug Assistance Program, Indiana State Department of Health, 2 North Meridian Street, Indianapolis, IN 46204

WEBSITE http://www.in.gov/isdh/17740.htm

Iowa

Iowa AIDS Drug Assistance Program

CALL 1-515 242-5150 or 1-866-227-9878

TTY 711 or 1-800-735-2942

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Iowa AIDS Drug Assistance Program, Iowa Department of Public Health, 321 E. 12th Street, Des Moines, IA 50319-0075

WEBSITE http://www.idph.iowa.gov/hivstdhep/hiv

Kansas

Kansas AIDS Drug Assistance Program

CALL 1-785-296-6174

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Kansas AIDS Drug Assistance Program, Kansas Department of Health and Environment, 1000 SW Jackson, Suite 210, Topeka, KS 66612

WEBSITE https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program-ADAP

Kentucky

Kentucky AIDS Drug Assistance Program

CALL 1-502-564-6539 or 1-800-420-7431

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Kentucky AIDS Drug Assistance Program, Kentucky Cabinet for Health and Family Services, Department for Public Health, HIV/AIDS Branch, 275 E. Main St. HS2E-C, Frankfort, KY 40621

WEBSITE https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana

Louisiana Drug Assistance Program (L-DAP)

CALL 1-504-568-7474

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Louisiana Drug Assistance Program (L-DAP), Louisiana Health Access Program (LA HAP), 1450 Poydras St. , Suite 2136, New Orleans, LA 70112

WEBSITE http://www.lahap.org/

Maine

Maine AIDS Drug Assistance Program

CALL 1-207-287-3747

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Maine AIDS Drug Assistance Program, Division of Infectious Disease, Center for Disease Control and Prevention, Department of Health and Human Services, 286 Water Street, 11 State House Station, Augusta, ME 04333-0011

WEBSITE https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/index.shtml

Maryland

Maryland AIDS Drug Assistance Program

CALL 1-410-767-6535 or 1-800-205-6308

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE Maryland AIDS Drug Assistance Program, Maryland Department of Health & Mental Hygiene, Center for HIV Care Services, 201 West Preston Street, Baltimore, MD 21201

WEBSITE https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx

Massachusetts

Massachusetts HIV Drug Assistance Program (HDAP)

CALL 1-617-502-1700 or 1-800-228-2714

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m.

WRITE Massachusetts HIV Drug Assistance Program (HDAP), Community Research Initiative of New England, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129

WEBSITE http://crine.org/hdap/

Michigan

Michigan Drug Assistance Program

CALL 1-888-826-6565

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Michigan Drug Assistance Program, HIV Care Section, Division of Health, Wellness and Disease Control, Michigan Department of Health and Human Services, 109 Michigan Avenue, 9th Floor, Lansing, MI 48913

WEBSITE https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program

Minnesota

Minnesota AIDS Drug Assistance Program

CALL 1-651-431-2414 or 1-800-657-3761

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE Minnesota AIDS Drug Assistance Program, Minnesota Department of Human Services, HIV/ AIDS Division, P.O. Box 64972, St. Paul, MN 55164-0972

WEBSITE http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

Mississippi

Mississippi AIDS Drug Assistance Program

CALL 1-601 576-7400 or 1-866-458-4948

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Mississippi AIDS Drug Assistance Program, Mississippi State Department of Health, Office of STD/HIV, P.O. Box 1700, Jackson, MS 39215

WEBSITE http://msdh.ms.gov/msdhsite/_static/14,13047,150.html

Missouri

Missouri AIDS Drug Assistance Program

CALL 1-573-751-6113 or 1-866-628-9891

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Missouri AIDS Drug Assistance Program, Missouri Department of Health & Senior Services, Bureau of HIV, STD, and Hepatitis, P.O. Box 570, Jefferson City, MO 65102-0570

WEBSITE http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

Montana

Montana AIDS Drug Assistance Program

CALL 1-406-444-4744

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Montana AIDS Drug Assistance Program, Montana Department of Public Health and Human Services, HIV/STD Section, P.O. Box 202951, Cogswell Building C211, Helena, MT 59620-2951

WEBSITE https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog

Nebraska

Nebraska AIDS Drug Assistance Program

CALL 1-402-471-2101

HOURS Monday – Thursday, 8:00 a.m. – 5:00 p.m., Friday, 9:00 a.m. – 3:30 p.m.

WRITE Nebraska AIDS Drugs Assistance Program, Ryan White Program, P.O. Box 95206, Lincoln, NE 68509-5026

WEBSITE https://dhhs.ne.gov/Documents/RyanWhiteAIDSdrugAssistanceProgram.pdf

Nevada

Nevada AIDS Drug Assistance Program

CALL 1-775-684-4056

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Nevada AIDS Drug Assistance Program, Nevada Division of Public and Behavioral Health, 4126 Technology Way, Suite 200, Carson City, NV 89706

WEBSITE http://dpbh.nv.gov/Programs/HIV-Ryan/ Ryan_White_Part_B_-_Home/

New Hampshire

New Hampshire AIDS Drug Assistance Program

CALL 1-603-271-9700 or 1-800-852-3345

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE New Hampshire AIDS Drug Assistance Program, New Hampshire Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301-3852

WEBSITE https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap

New Jersey

New Jersey AIDS Drug Distribution Program (ADDP)

CALL 1-877-613-4533 or 1-800-624-2377

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE New Jersey AIDS Drug Distribution Program (ADDP), New Jersey Department of Health, P.O. Box 360, Trenton, NJ 08625

WEBSITE http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml

New Mexico

New Mexico AIDS Drug Assistance Program

CALL 1-505-476-3628

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE New Mexico AIDS Drug Assistance Program, 1190 S. St. Francis Drive, Santa Fe, NM 87505

WEBSITE https://nmhealth.org/about/phd/idb/hats/

New York

New York AIDS Drug Assistance Program

CALL 1-518-459-1641 or 1-800-542-2437

TTY 1-518-459-0121

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE New York AIDS Drug Assistance Program, New York Department of Health, HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052

WEBSITE http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm

North Carolina

North Carolina HIV Medication Assistance Program (HMAP)

CALL 1-919 733-9161 or 1-877-466-2232

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE North Carolina HIV Medication Assistance Program (HMAP), NC Department of Health and Human Services, Communicable Disease Branch, Epidemiology Section, Division of Public Health, 1902 Mail Service Center, Raleigh, NC 27699-1902

WEBSITE http://epi.publichealth.nc.gov/cd/hiv/hmap.html

North Dakota

North Dakota Department of Health HIV/AIDS Program

CALL 1-701 328-2378 or 1-800-472-2180

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE North Dakota Department of Health, HIV/AIDS Program, 2635 East Main Ave., Bismarck, ND 58506-5520

WEBSITE https://www.ndhealth.gov/hiv/

Ohio

Ohio HIV Drug Assistance Program

CALL 1-800-777-4775

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Ohio HIV Drug Assistance Program, Ohio Department of Health, HIV Care Services Section, 246 North High Street, Columbus, OH 43215

WEBSITE https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/resources

Oklahoma

Oklahoma State Department of Health

CALL 1-405-271-4636 or 1-800-522-0203

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Oklahoma State Department of Health, 1000 NE 10th, Room 614, Oklahoma City, OK 73117

WEBSITE https://oklahoma.gov/health.html

Oregon

CAREAssist

CALL 1-971-673-0144 or 1-800-805-2313

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE CAREAssist, Oregon Health Authority, 800 NE Oregon Street, Suite 1105, Portland, OR 97232

WEBSITE https://www.oregon.gov/oha/ph/diseasesconditions/hivstdviralhepatitis/hivcaretreatment/careassist/pages/index.aspx

Pennsylvania

Special Pharmaceutical Benefits Program

CALL 1-800-922-9384

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Special Pharmaceutical Benefits Program, Pennsylvania Department of Health, 625 Forster St., H&W Bldg., Rm 611, Harrisburg, PA 17120

WEBSITE https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx

Puerto Rico

MC-21

CALL (787) 286-6032

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE MC-21, Road #1 Km. 33.3 Lot #4, Angora Industrial Park, Bo. Bairoa, Caguas, P.R. 00725

Rhode Island

Rhode Island AIDS Drug Assistance Program

CALL 1-401-462-3294

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE Rhode Island AIDS Drug Assistance Program, RI Department of Health, Office of HIV/AIDS & Viral Hepatitis, 3 Capitol Hill, Room 302, Providence, RI 02908

WEBSITE http://www.health.ri.gov/diseases/hivaids/about/stayinghealthy/

South Carolina

South Carolina AIDS Drug Assistance Program

CALL 1-800-856-9954

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE South Carolina AIDS Drug Assistance Program, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201

WEBSITE http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/

South Dakota

Ryan White Part B CARE Program

CALL 1-605-773-3737 or 1-800-592-1861

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th St., Pierre, SD 57501-1700

WEBSITE http://doh.sd.gov/diseases/infectious/ryanwhite/

Tennessee

Tennessee HIV Drug Assistance Program (HDAP)

CALL 1-615-532-2392

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Tennessee HIV Drug Assistance Program (HDAP), Tennessee Department of Health, 710 James Robertson Parkway, Andrew Johnson Tower, Nashville, TN 37243

WEBSITE https://www.tn.gov/health/health-program-areas/std/std/ryanwhite.html

Texas

Texas HIV Medication Program

CALL 1-800-255-1090

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Texas HIV Medication Program, MSJA, MC 1873, P.O. Box 149347, Austin, TX 78714-9347

WEBSITE http://www.dshs.texas.gov/hivstd/meds/

Utah

Utah AIDS Drug Assistance Program

CALL 1-801-538-6397

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Utah AIDS Drug Assistance Program, Utah Department of Health, Bureau of Epidemiology, 288 North 1460 West, Box 142104, Salt Lake City, UT 84114-2104

WEBSITE https://ptc.health.utah.gov/treatment/ryan-white/

Vermont

Vermont Medication Assistance Program (VMAP)

CALL 1-802-951-4005

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Vermont AIDS Drug Assistance Program, Vermont Department of Health, HIV/AIDS Program, 108 Cherry Street, Burlington, VT 05402

WEBSITE HIV Care | Vermont Department of Health (healthvermont.gov)

Virginia

Virginia Medication Assistance Program (VA MAP)

CALL 1-855-362-0658

TTY 711.0

HOURS Monday and Wednesday, 8:00 a.m. – 6:00 p.m., Tuesday, Thursday and Friday, 8:00 a.m. – 5:00 p.m.

WRITE Virginia Medication Assistance Program (VA MAP) Virginia Department of Health, Eligibility, 1st Floor, 109 Governor Street, Room 326, P.O. Box 2448, Richmond, VA 23218

WEBSITE https://www.vdh.virginia.gov/disease-prevention/eligibility/

Washington

Early Intervention Program (EIP)

CALL 1-360-236-3426 or 1-877-376-9316

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Early Intervention Program (EIP), Washington State Department of Health, P.O. Box 47841, Olympia, WA 98504-7841

WEBSITE https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services

West Virginia

West Virginia AIDS Drug Assistance Program

CALL 1-304-558-2195 or 1-800-642-8244

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE West Virginia AIDS Drug Assistance Program, West Virginia Department of Health and Human Resources, 350 Capital Street, Room 125, Charleston, WV 25301

WEBSITE https://oeps.wv.gov/rwp/pages/default.aspx

Wisconsin

Wisconsin AIDS/HIV Drug Assistance Program

CALL 1-608-267-6875 or 1-800-991-5532

HOURS Monday – Friday, 7:00 a.m. – 4:30 p.m.

WRITE Wisconsin AIDS/HIV Drug Assistance Program, Wisconsin Department of Health Services, Attn: ADAP, P.O. Box 2659, Madison, WI 53701-2659

WEBSITE http://www.dhs.wisconsin.gov/aids-hiv/Resources/Overviews/AIDS_HIV_drug_reim.htm

Wyoming

Wyoming AIDS Drug Assistance Program

CALL 1-307-777-5856

HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.

WRITE Wyoming AIDS Drug Assistance Program, Wyoming Department of Health, 6101 Yellowstone Road, Suite 510, Cheyenne, WY 82002

WEBSITE https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/

Multi-language Interpreter Services

English – ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call **1-888-281-7867** (TTY 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-281-7867** (TTY 711).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-281-7867** (TTY 711)。

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-281-7867** TTY 711).

French Creole – ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-281-7867** (TTY 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-281-7867** (TTY 711)번으로 전화해 주십시오.

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-888-281-7867** (TTY 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-281-7867** (ATS 711).

Arabic – ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-281-7867** (TTY 711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-281-7867** (телетайп 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-281-7867** (TTY 711).

Farsi/Persian – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-281-7867** (TTY: 711) تماس بگیرید.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-281-7867** (TTY 711).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-281-7867** (TTY 711).

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-281-7867** (TTY 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-281-7867** (TTY 711)まで、お電話にてご連絡ください。

Navajo – Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-888-281-7867** (TTY 711).

Gujarati – ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-281-7867** (TTY 711).

Urdu توجہ دیں: اگرآپ اردو زبان بولتے ہیں تو آپ کےلئے زبان معاون خدمات مفت میں دستیاب ہیں۔ کال کریں **1-888-281-7867** (TTY 711)

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Method	Customer Service – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.* Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
FAX	1-888-766-6403
WRITE	Cigna, Attn: Member Services, P.O. Box 2888, Houston, TX 77252
WEBSITE	cignamedicare.com/group/maresources

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