January 1 – December 31, 2026

Evidence of Coverage for 2026:

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

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

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

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

For questions about this document, call Customer Service at 1-888-281-7867 (TTY users call 711). Calls to this number are free. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.

This plan, HealthSpring True Choice Core (PPO), is offered by HealthSpring. (When this *Evidence of Coverage* says "we," "us," or "our," it means HealthSpring. When it says "plan" or "our plan," it means HealthSpring 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, premiums, deductibles, and/or copayment/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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

Table of Contents

CHAPTER 1:
Get started as a member

SECTION 1 You're a member of HealthSpring True Choice Core (PPO)

Section 1.1 You're enrolled in HealthSpring True Choice Core (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, HealthSpring True Choice Core (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

HealthSpring True Choice Core (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D drug coverage.

Section 1.2 Legal information about the Evidence of Coverage

This Evidence of Coverage is part of our contract with you about how HealthSpring True Choice Core (PPO) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for the months you're enrolled in HealthSpring True Choice Core (PPO) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of HealthSpring True Choice Core (PPO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Section 2.2 Plan service area for HealthSpring True Choice Core (PPO)

HealthSpring True Choice Core (PPO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

If you move out of our plan's service area, you can't stay a member of this plan. Call your Plan Sponsor to see if they have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

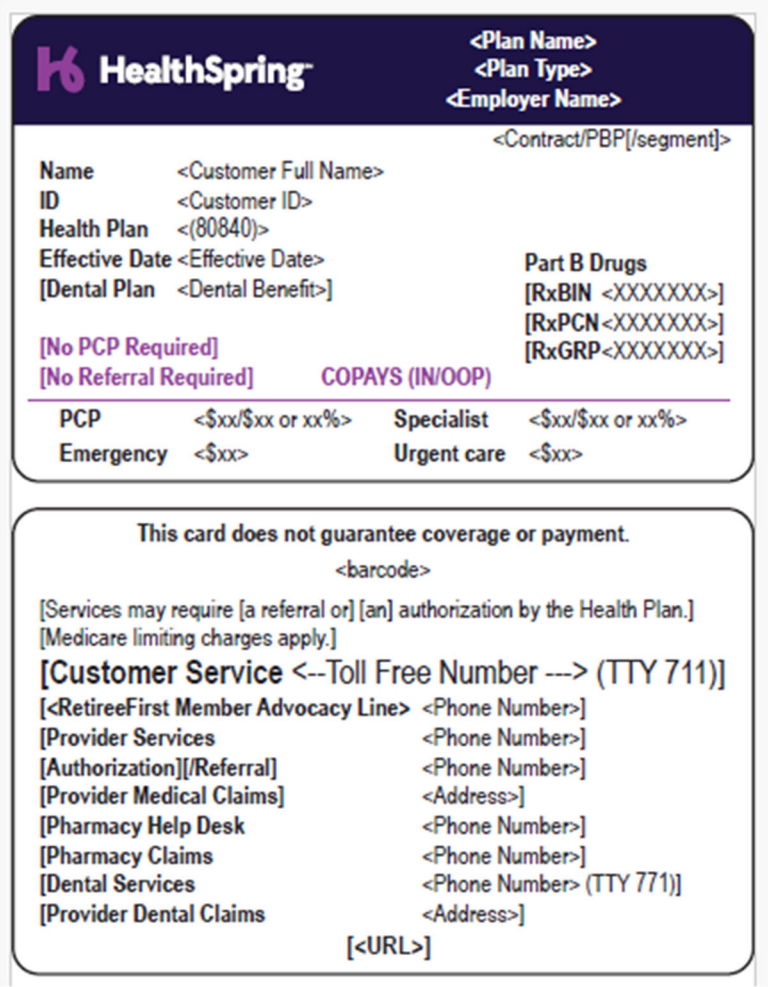
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify HealthSpring True Choice Core (PPO) if you're not eligible to stay a member of our plan on this basis. HealthSpring True Choice Core (PPO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your HealthSpring True Choice Core (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 research studies (also called clinical trials).

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

Section 3.2 Provider Directory

The *Provider Directory* www.HealthSpring.com/GroupMA lists our current 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.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Service. Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important costs for *HealthSpring True Choice Core (PPO)*

	Your Costs in 2026
Monthly plan premium* *Go to Section 4.1 for details.	**Contact your Plan Sponsor**
Deductible	**Refer to the *Evidence of Coverage Snapshot*** **Deductible does not apply to insulin furnished through an item of durable medical equipment.**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered services. (Go to Chapter 4 Section 1 for details.)	**Refer to the *Evidence of Coverage Snapshot***

	Your Costs in 2026
Primary care office visits	**Refer to the *Evidence of Coverage Snapshot***
Specialist office visits	**Refer to the *Evidence of Coverage Snapshot***
Inpatient hospital stays	**Refer to the *Evidence of Coverage Snapshot***

Your costs may include the following:

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

Section 4.1 Plan premium

Your coverage is provided through a contract with your current employer or former employer or union. Contact the employer's or union's benefits administrator for information about our plan premium.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums you must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Optional Supplemental Benefit Premium

There is no separate premium amount for any supplemental benefits described in the *Evidence of Coverage Snapshot.*

SECTION 5 More information about your monthly premium

Section 5.1 How to pay our plan premium

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

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep our plan membership record up to date

The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

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

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

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

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The one that pays second (the "secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 HealthSpring True Choice Core (PPO) contacts

For help with claims, billing or member card questions, call or write to HealthSpring True Choice Core (PPO) Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
Call	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours. 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 hearing or speaking. Calls to this number are free. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.
Fax	*1-888-766-6403*
Write	HealthSpring True Choice Core (PPO) Attn: Medicare Customer Service PO Box 1002 Nashville, TN 37202
Website	www.HealthSpring.com/GroupMA

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions and Appeals 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 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours. 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 hearing or speaking. Calls to this number are free. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.
Fax	1-888-766-6403
Write	HealthSpring Attn: Precertification Department PO Box 188081 Chattanooga, TN 37422
Website	www.HealthSpring.com/GroupMA

How to make 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 doesn't involve coverage or payment

disputes. For more information on how make a complaint about your medical care, go to Chapter 7.

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 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours. 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 hearing or speaking. Calls to this number are free. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.
Fax	1-888-766-6403
Write	HealthSpring, Attn: Medicare Grievance Dept, PO Box 188080, Chattanooga, TN 37422
Medicare website	To submit a complaint about HealthSpring True Choice Core (PPO) directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.
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 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.
Write	**Part C (Medical Services)** HealthSpring Attn: DMR - Medical Claims PO Box 1004 Nashville, TN 37202
Website	www.HealthSpring.com/GroupMA

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with 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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about *HealthSpring True Choice Core (PPO)*. **To submit a complaint to Medicare,** go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Refer to Appendix A for a list of SHIP programs.

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

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

SECTION 4 Quality Improvement Organization (QIO)

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

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state.

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

Contact the QIO in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security– Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, 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. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (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 Medicare Savings Programs, refer to Appendix C.

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

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

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 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 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 Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, HealthSpring True Choice Core (PPO) must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

HealthSpring True Choice Core (PPO) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in the *Evidence of Coverage Snapshot*.
- **The care you get 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 get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
    - The providers in our network are listed in the *Provider Directory* www.HealthSpring.com/GroupMA.
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
    - 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 can't 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'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

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

Section 2.1 You may choose a Primary Care Provider (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 do so and to 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.

How to choose a 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 www.HealthSpring.com/GroupMA. If you need help, you can call Customer Service for assistance. You can also change your PCP by contacting Customer Service.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP.

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 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccines, hepatitis B vaccines, and pneumonia vaccines
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency), if you're either temporarily outside our plan's service area or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside the service area of our plan or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never exceed the cost sharing in Original Medicare. If you're outside our plan's service area and get the dialysis from a provider that is outside our plan's network, your cost sharing can't exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is available and you choose to get services inside the service area from a provider outside our plan's network, the cost sharing for the dialysis may be higher.

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. For example:

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

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Call Customer Service to see if prior authorization is needed.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't 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 covered services may be higher. Here are more 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 can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary. (Go to Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7 to learn how to make an appeal).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 5).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

Section 2.5 How to get care if you live in a non-network area

Contact Customer Service.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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're 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's 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can 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're not part of our network.
- **As soon as possible, make sure 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. *Call the toll-free number on the back of your membership card.*

Covered services in 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 giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're 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.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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 Get 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're still entitled to care from our plan.

Visit www.HealthSpring.com/GroupMA for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

HealthSpring True Choice Core (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're 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 use 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 Medical services 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 ask for volunteers to participate in the study. When you're in a clinical research study, you can 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 participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't 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 don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need 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 not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays 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'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. 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 our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies,* available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 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'll instead cover 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 How to get 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're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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 only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't 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 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME 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 HealthSpring True Choice Core (PPO), you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances we'll 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 didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count toward these 13 payments.

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 don't count. You'll have to make 13 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage HealthSpring True Choice Core (PPO) 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 HealthSpring True Choice Core (PPO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

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

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of HealthSpring True Choice Core (PPO). This section also gives information about medical services that aren't covered. Refer to the *Evidence of Coverage Snapshot* for the list of your covered services and the cost-shares for those services.

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

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (The Medical Benefits Chart in the *Evidence of Coverage Snapshot* tells you more about your deductible.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** 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 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan deductible

Your deductible, if your plan has one, is located in the *Evidence of Coverage Snapshot*. Until you've paid the deductible amount, you must pay the full cost for most of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services, and you'll pay your share for the rest of the calendar year.

The deductible doesn't apply to some services, including certain in-network preventive services. This means that we pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible doesn't apply to the following services:

Section 1.3 Our plan may have a deductible for certain types of services from network providers

If there is a deductible, until you have paid the deductible amount, you must pay the full cost for services. After you pay your deductible, we'll pay our share of the costs for these services, and you'll pay your share. The Medical Benefits Chart in the *Evidence of Coverage Snapshot* shows any service category deductibles.

Section 1.4 What's the most you'll pay for Medicare Part A and Part B covered medical services?

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

Section 1.5 Our plan may also limits your out-of-pocket costs for certain types of services

Refer to the *Evidence of Coverage Snapshot* to see if other limits apply.

Section 1.6 Providers aren't allowed to balance bill you

As a member of HealthSpring True Choice Core (PPO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for 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's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).

  - If you get 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 get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Customer Service.

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the *Evidence of Coverage Snapshot* lists the services HealthSpring True Choice Core (PPO) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B 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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
  - Covered services that need approval in advance to be covered as in-network services are marked in bold in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

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 get the services from:

  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get 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 get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- 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.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.
- This apple shows preventive services in the Medical Benefits Chart found in the *Evidence of Coverage Snapshot*.

Medical Benefits Chart – refer to the Evidence of Coverage Snapshot

Section 2.1 Extra optional supplemental benefits

If your plan offers some extra benefits that aren't covered by Original Medicare, they are called **Optional Supplemental Benefits.** These are described in the *Evidence of Coverage Snapshot* if they apply to your plan and are subject to the same appeals process as any other benefits.

Section 2.2 Get care using our plan's optional visitor/traveler benefit

Refer to the *Evidence of Coverage Snapshot* to see if your plan has world-wide coverage benefits.

If you don't permanently move but are continuously away from our plan's service area for more than 6 months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program, that will allow you to stay enrolled when you're outside of our service area for less than 12 months. Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Contact our plan for help locating a provider when using the visitor/traveler benefit.

If you're in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you don't return to our plan's service area within 12 months, you'll be disenrolled from our plan.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart in the *Evidence of Coverage Snapshot* lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed in the *Evidence of Coverage Snapshot*. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

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

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to 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 got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got medical care from a provider who isn't in our plan's network**

   When you get care from a provider who is not part of our network, you're 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 our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get 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 made.

- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
    - If the provider is owed anything, we'll pay the provider directly.
    - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- 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 can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our 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 covered services. We don't 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's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.

If you were retroactively enrolled in our plan and you paid out of pocket for any covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask 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. **You must submit your claim to us within *12 months*** of the date you got the service or item.

To make sure you're 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'll help us process the information faster.
- Download a copy of the form from our website (www.HealthSpring.com/GroupMA) or call Customer Service and ask for the form.

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

For Part C (Medical Services) Claims
HealthSpring
Attn: Direct Member Reimbursement, Medical Claims
PO Box 1004
Nashville, TN 37202

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

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the medical care, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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 details on how to make this appeal, go to Chapter 7.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't 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 in languages other than English and braille, and large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, 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 our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get 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, seeing a women's health specialist or finding a network specialist, call to file a grievance using the contact information in Chapter 2. You can 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.

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

You have the right to choose a provider in our 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 have the right to get appointments and covered services from your 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 you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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. *Plans are permitted to include the Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 C.F.R. § 164.520).*

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're *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 don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're 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's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

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

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

As a member of HealthSpring True Choice Core (PPO), you have the right to get several kinds of information from us.

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

- **Information about our plan**. This includes, for example, information about our 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 isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're 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. 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's to be done if you can't make medical decisions for yourself

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

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

Legal documents you can use to give your directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Service to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.

- **Give copies of the form to the right people.**
  Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you 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're going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with 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 ask us to reconsider decisions we made

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

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Service**
- **Call your local SHIP**
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service**
- **Call your local SHIP**
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverag*e to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our 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 you and your doctors agree on.

  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you**.**
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

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

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Refer to Appendix A for contact information.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9**, **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover a medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help when asking for a coverage decision or making an appeal

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

- **Call Customer Service**
- **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 need to be appointed as your representative. Call Customer Service and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf)
    - For medical care or Part B drugs, your doctor can ask for 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.** 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 another person to be your representative, call Customer Service and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
- We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines We give the details for each one of these situations in this chapter:

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

If you're not sure which information applies to you, call Customer Service. You can also get help or information from your SHIP.

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

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

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to ask for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't 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 won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've 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, go to Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll 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 asked for.

Step 2: 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.

Step 3: 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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get 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 calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll 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. Go to Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **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 we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll 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.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're 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 65 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 asking for 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.**

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - 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'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request 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 asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 of this chapter for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll 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 asked for,** 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 Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't 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'll 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 the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

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

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

- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent 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 shouldn't 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:

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

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got 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're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed 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 the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll 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 won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you have already received and paid for, you aren't 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 asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're 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'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

- Your right to get 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 the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got 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 got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, 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, call Customer Service. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: 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 got (*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 Chapter 2.

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 can 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 don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll 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's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.

- By noon of the day after the reviewers told us of your appeal, you'll 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's 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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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 independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 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 its 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 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 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 the information related to your appeal.

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

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent 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 want to continue with the review process.

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

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

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep

getting your 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's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask 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 got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 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'll 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, call Customer Service. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 who are paid by the federal government to check on and 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 aren't part of our plan.

Step 1: 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 got (*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*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll 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 its 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's medically necessary.**
- You'll 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 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, **you'll 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 7.3 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 calendar 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 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 the information related to your appeal.

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go 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 need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 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 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 8 Taking your appeal to Levels 3, 4, and 5

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

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way at the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't 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'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll 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 don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

SECTION 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 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 got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
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 our plan? o 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?

Complaint	Example
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Customer Service is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Submit your **written complaint** to the following address:

  HealthSpring
  Attn: Medicare Grievance Dept.
  PO Box 188080
  Chattanooga, TN 37422

or you may email your grievance to: Member.Grievances@HealthSpring.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'll 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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

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

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about HealthSpring True Choice Core (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in HealthSpring True Choice Core (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

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

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

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year**. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan,
    - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

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

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare enrollees who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without drug coverage.
    - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same 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 drug plan, your membership in the drug plan will start 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 HealthSpring True Choice Core (PPO) 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 our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your

membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

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

Your membership will usually end on the first day of the month after we get your request to change our plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service**
- Find the information in the ***Medicare & You 2026*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from HealthSpring True Choice Core (PPO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from HealthSpring True Choice Core (PPO) when your new plan's coverage starts.
Original Medicare *without* a separate Medicare 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) and ask to be disenrolled. TTY users call 1-877-486-2048.

	• You'll be disenrolled from HealthSpring True Choice Core (PPO) when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) 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 drug coverage for 63 days or more in a row.

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

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services through our plan.

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

SECTION 5 HealthSpring True Choice Core (PPO) must end our plan membership in certain situations

HealthSpring True Choice Core (PPO) must end your membership in our 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're away from our service area for more than 6 months
  - If you move or take a long trip, call Customer Service to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- 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 can't 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 can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

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

Section 5.1 We can't ask you to leave our plan for any health-related reason

HealthSpring True Choice Core (PPO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you 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

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare 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, 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.html.

If you have a disability and need help with access to care, call 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, HealthSpring True Choice Core (PPO), 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.

CHAPTER 10: Definitions

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 doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

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

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or 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 hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. 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 MA eligible people who have specific severe and chronic diseases.

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

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. Refer to the *Evidence of Coverage Snapshot* 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 about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods 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. 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 are gotten. (This is in addition to our plan's monthly premium.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all 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 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't 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 pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

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

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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

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 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 plan or providers including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't 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 the 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. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue

to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've 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.

Initial Enrollment Period – When you're 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'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from 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 (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

Low Income Subsidy (LIS) –Go to 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, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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 time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get 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 a person 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 i) an HMO, ii) a 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 the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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

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

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**.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits to get them.

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

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 such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization 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're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical 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.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), 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. Our plan must disenroll you if you permanently move out of our 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 – 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 live 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

SHIP

AK

State Health Insurance Assistance Program

CALL 1-907-269-3680 or 1-800-478-6065 or TTY 1-800-770-8973

WRITE State Health Insurance Assistance Program, Alaska Dept. of Health, Division of Senior & Disabilities Services, 1835 Bragaw Street, Suite 350, Anchorage, AK 99508

WEBSITE https://health.alaska.gov/en/senior-and-disabilities-services/medicare-office/

AL

Alabama State Health Insurance Assistance Program

CALL 1-800-243-5463

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

WEBSITE https://alabamaageline.gov/ship/

AR

Arkansas Senior Health Insurance Information Program (AR SHIIP)

CALL 1-800-224-6330

WRITE Arkansas Senior Health Insurance Information Program (AR SHIIP), Arkansas Insurance Department, 1 Commerce Way, Little Rock, AR 72201

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

AZ

State Health Insurance Assistance Program

CALL 1-800-432-4040 or TTY 711

WRITE State Health Insurance Assistance Program, Department of Economic Security, Division of Aging and Adult Services (DAAS), 1789 W. Jefferson Street, #6272, Phoenix, AZ 85007

WEBSITE https://des.az.gov/medicare-assistance

CA

Health Insurance Counseling & Advocacy Program (HICAP)

CALL 1-916-465-8104 or 1-800-434-0222 or TTY 1-800-735-2929

WRITE Health Insurance Counseling & Advocacy Program (HICAP), California Health Advocates, 5380 Elvas Avenue, Suite 221, Sacramento, CA 95819

WEBSITE https://cahealthadvocates.org/hicap/

CO

State Health Insurance Assistance Program

CALL 1-888-696-7213 or TTY 1-303-894-7880

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

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

CT

CHOICES

CALL 1-860-424-5055 or 1-800-994-9422 or TTY 1-860-247-0775

WRITE CHOICES, Department of Aging and Disability Services, Central Office, 55 Farmington Avenue, 12th Floor, Hartford, CT 06105

WEBSITE https://portal.ct.gov/ads-choices

DC

State Health Insurance Assistance Program (SHIP)

CALL 1-202-727-8370 or TTY 711

WRITE State Health Insurance Assistance Program (SHIP), 250 E Street SW, Washington, DC 20024

WEBSITE https://dacl.dc.gov/service/health-insurance-counseling

DE

Delaware Medicare Assistance Bureau (DMAB)

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

WRITE Delaware Medicare Assistance Bureau (DMAB), Delaware Department of Insurance, 841 Silver Lake Boulevard, Suite 100, Dover, DE 19904

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

FL

SHINE (Serving Health Insurance Needs of Elders)

CALL 1-800-963-5337 or TTY 1-800-955-8770

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

WEBSITE https://www.floridashine.org/

GA

Georgia SHIP

CALL 1-866-552-4464 (Option 4) or TTY 1-404-657-1929

WRITE Georgia SHIP, Georgia Department of Human Services, Division of Aging Services, 47 Trinity Avenue SW, Atlanta, GA 30334

WEBSITE https://aging.georgia.gov/georgia-ship

HI

Hawaii SHIP

CALL 1-808-586-7299 or 1-888-875-9229 or TTY 1-866-810-4379

WRITE Hawaii SHIP, Executive Office on Aging, Hawaii State Department of Health, No. 1 Capitol District, 250 S. Hotel Street, Suite 406, Honolulu, HI 96813-2831

WEBSITE https://www.hawaiiship.org/

IA

Senior Health Insurance Information Program (SHIIP)

CALL 1-800-351-4664 or TTY 1-800-735-2942

WRITE Senior Health Insurance Information Program (SHIIP), Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, IA 50315

WEBSITE https://shiip.iowa.gov/senior-health-insurance-information-program-shiip

ID

Senior Health Insurance Benefits Advisors (SHIBA)

CALL 1-800-247-4422

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

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

IL

Senior Health Insurance Program (SHIP)

CALL 1-800-252-8966 or TTY 711

WRITE Senior Health Insurance Program (SHIP), Illinois Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271

WEBSITE https://ilaging.illinois.gov/ship.html

IN

State Health Insurance Assistance Program (SHIP)

CALL 1-800-452-4800 or 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 https://www.in.gov/ship/

KS

Senior Health Insurance Counseling for Kansas (SHICK)

CALL 1-800-860-5260 or TTY 1-785-291-3167

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

WEBSITE https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick

KY

State Health Insurance Assistance Program (SHIP)

CALL 1-502-564-6930 or 1-877-293-7447 (option 2) or TTY 1-800-648-6056

WRITE State Health Insurance Assistance Program (SHIP), Cabinet for Health and Family Services, Department for Aging and Independent Living (DAIL), 275 East Main Street 3E-E, Frankfort, KY 40621

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

LA

Louisiana Senior Health Information Program (LaSHIP)

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

WRITE Louisiana Senior Health Information Program (LaSHIP) , Louisiana Department of Insurance, P.O. Box 94214, Baton Rouge, LA 70804

WEBSITE https://www.ldi.la.gov/consumers/senior-health-shiip

MA

Serving the Health Insurance Needs of Everyone (SHINE)

CALL 1-800-243-4636 or TTY 1-800-439-2370

WRITE Serving the Health Insurance Needs of Everyone (SHINE), Executive Office of Elder Affairs, One Ashburton Place, 10th Floor, Boston, MA 02108

WEBSITE https://www.mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program

MD

State Health Insurance Assistance Program (SHIP)

CALL 1-410-767-1100 or 1-800-243-3425 or TTY 711

WRITE State Health Insurance Assistance Program (SHIP), Maryland Department of Aging, 301 West Preston Street, Suite 1007, Baltimore, MD 21201

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

ME

Maine State Health Insurance Program (SHIP)

CALL 1-207-287-3707 or 1-877-353-3771 or TTY 711

WRITE Maine State Health Insurance Program (SHIP), Department of Health and Human Services, 109 Capitol Street, 11 State House Station, Augusta, ME 04333

WEBSITE https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance

MI

Michigan Medicare Assistance Program (MMAP)

CALL 1-800-803-7174

WRITE Michigan Medicare Assistance Program (MMAP), 6105 West St. Joseph Highway, Suite 204, Lansing, MI 48917

WEBSITE https://www.aaawm.org/MMAP

MN

Minnesota Senior LinkAge Line (SHIP)

CALL 1-800-333-2433 or TTY 1-800-627-3529

WRITE Minnesota Senior LinkAge Line, Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164

WEBSITE https://mn.gov/board-on-aging/direct-services/senior-linkage-line/

MO

Missouri SHIP

CALL 1-800-390-3330

WRITE Missouri SHIP, 601 West Nifong Boulevard, Suite 3A, Columbia, MO 65203

WEBSITE https://www.missouriship.org/

MS

State Health Insurance Assistance Program (SHIP)

CALL 1-601-359-4500 or 1-844-822-4622

WRITE State Health Insurance Assistance Program (SHIP), Mississippi Department of Human Services, Division of Aging & Adult Services, 200 S. Lamar Street, Jackson, MS 39201

WEBSITE http://www.mdhs.ms.gov/aging/finding-services-for-older-adults

MT

Montana State Health Insurance Assistance Program (SHIP)

CALL 1-406-444-4077 or 1-800-551-3191

WRITE Montana State Health Insurance Assistance Program (SHIP), Department of Public Health & Human Services, Senior and Long Term Care Division, PO Box 4210, Helena, MT 59604

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

NC

Seniors' Health Insurance Information Program (SHIIP)

CALL 1-855-408-1212

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

WEBSITE https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip

ND

State Health Insurance Assistance Program (SHIP)

CALL 1-701-328-2440 or 1-888-575-6611 or TTY 1-800-366-6888

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

WEBSITE https://www.insurance.nd.gov/consumers/medicare

NE

Nebraska SHIP (State Health Insurance Assistance Program)

CALL 1-402-471-2201 or 1-800-234-7119 or TTY 1-800-833-7352

WRITE Nebraska SHIP, Nebraska Department of Insurance, P.O. Box 95087, Lincoln, NE 68509-5087

WEBSITE https://doi.nebraska.gov/nebraska-ship-smp

NH

State Health Insurance Assistance Program (SHIP)

CALL 1-866-634-9412 or TTY 1-800-735-2964

WRITE State Health Insurance Assistance Program (SHIP), 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 033

WEBSITE https://www.dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers/aging-disability-6

NJ

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, Trenton, NJ 08625-0715

WEBSITE https://www.nj.gov/humanservices/doas/services/q-z/ship/

NM

State Health Insurance Assistance Program (SHIP)

CALL 1-800-432-2080 or TTY 1-505-476-4937

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

WEBSITE https://aging.nm.gov/

NV

Nevada Medicare Assistance Program (MAP)

CALL 1-775-687-4210 or 1-800-307-4444

WRITE Nevada Medicare Assistance Program (MAP), Nevada Aging and Disability Services Division, 1550 E. College Parkway, Carson City, NV 89706

WEBSITE https://adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_(MAP)/MAP_Prog/

NY

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, 5th Floor, Albany, NY 12223-1251

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

OH

Ohio Senior Health Insurance Information Program (OSHIIP)

CALL 1-800-686-1578 or TTY 1-614-644-3745

WRITE Ohio Senior Health Insurance Information Program (OSHIIP), The Ohio Department of Insurance, 50 West Town Street, Suite 300, Columbus, OH 43215

WEBSITE https://insurance.ohio.gov/consumers/medicare/01-oshiip

OK

Senior Health Insurance Counseling Program (SHIP)

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

WRITE Senior Health Insurance Counseling Program (SHIP), Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City , OK 73105

WEBSITE https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/

OR

Senior Health Insurance Benefits Assistance Program (SHIBA)

CALL 1-800-722-4134 or TTY 711

WRITE Senior Health Insurance Benefits Assistance Program (SHIBA), Oregon Department of Human Services, 500 Summer Street NE E-15, Salem, OR 97301

WEBSITE https://shiba.oregon.gov/Pages/index.aspx?utm_source=shiba&utm_medium=egov_redirect&utm_campaign=https%3A%2F%2Fhealthcare.oregon.gov%2Fshiba%2F

PA

Pennsylvania Medicare Education and Decision Insight (PA MEDI)

CALL 1-800-783-7067

WRITE Pennsylvania Medicare Education and Decision Insight (PA MEDI), Pennsylvania Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919

WEBSITE https://www.pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling.html

PR

Programa Estatal de Asistencia Sobre Seguros de Salud

CALL 1-787-721-6121 or 1-877-725-4300

WRITE Programa Estatal de Asistencia Sobre Seguros de Salud, Oficina del Procurador de las Personas de edad avanzada, P.O. Box 191179, San Juan, PR 00919-1179

WEBSITE https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx

RI

State Health Insurance Assistance Program (SHIP)

CALL 1-401-462-3000 or 1-888-884-8721 or TTY 1-401-462-0740

WRITE State Health Insurance Assistance Program (SHIP), Rhode Island Office of Healthy Aging, 25 Howard Avenue, Louis Pasteur Building #57, Cranston, RI 02920

WEBSITE https://oha.ri.gov/Medicare

SC

State Health Insurance Assistance Program (SHIP)

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

WRITE State Health Insurance Assistance Program, South Carolina Department on Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201

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

SD

Senior Health Information & Insurance Education (SHIINE)

CALL 1-800-536-8197

WRITE Senior Health Information & Insurance Education (SHIINE), South Dakota Department of Human Services, Division of Long Term Services and Support, Hillsview Plaza, 3800 East Highway 34, c/o 500 East Capitol Avenue, Pierre, SD 57501

WEBSITE https://dhs.sd.gov/en/ltss/shiine

TN

Tennessee State Health Insurance Assistance Program (TN SHIP)

CALL 1-877-801-0044 or TTY 1-800-848-0299

WRITE Tennessee State Health Insurance Assistance Program (TN SHIP), Department of Disability & Aging, UBS Tower, 8th Floor, 315 Deaderick Street, Nashville, TN 37243-1403

WEBSITE https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html

TX

Texas Health Information Counseling & Advocacy Program (HICAP)

CALL 1-800-252-9240 or TTY 711 or 1-800-735-2989

WRITE Texas Health Information Counseling & Advocacy Program (HICAP), Texas Health and Human Services, P.O. Box 13247, Austin, TX 78711-3247

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

UT

State Health Insurance Assistance Program (SHIP)

CALL 1-800-541-7735

WRITE State Health Insurance Assistance Program (SHIP), Utah Department of Health & Human Services, Division of Aging and Adult Services, Cannon Health Building, 288 North 1460 West, Salt Lake City, UT 84116

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

VA

Virginia Insurance Counseling & Assistance Program (VICAP)

CALL 1-804-662-9333 or 1-800-552-3402 or TTY 711

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

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

VT

Vermont State Health Insurance Assistance Program (SHIP)

CALL 1-800-642-5119

WRITE Vermont Association for Area Agencies on Aging, Vermont State Health Insurance Assistance Program (SHIP), 27 Main Street, Suite 14, Montpelier, VT 05602

WEBSITE https://www.vermont4a.org/medicare-information

WA

Statewide Health Insurance Benefits Advisors (SHIBA)

CALL 1-800-562-6900 or TTY 1-360-586-0241

WRITE Statewide Health Insurance Benefits Advisors (SHIBA), Office of the Insurance Commissioner, P.O. Box 40255, Olympia, WA 98504-0255

WEBSITE https://www.insurance.wa.gov/how-we-can-help-you-medicare

WI

State Health Insurance Assistance Program (SHIP)

CALL 1-800-242-1060 or TTY 711 or 1-800-947-3529

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

WEBSITE https://dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

WV

West Virginia SHIP

CALL 1-304-558-3317 or 1-877-987-3646

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

WEBSITE www.wvship.org/

WY

Wyoming State Health Insurance Information Program (WSHIIP)

CALL	1-800-856-4398
WRITE	Wyoming State Health Insurance Information Program (WSHIIP), 106 West Adams Avenue, Riverton, WY 82501
WEBSITE	https://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

QIO

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CALL	1-888-305-6759 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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CALL	1-888-317-0751 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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CALL	1-888-315-0636 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

AZ

Livanta

CALL	1-877-588-1123 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

CA

Livanta

CALL	1-877-588-1123 or TTY 711
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WEBSITE	https://www.livantaqio.cms.gov/en

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WEBSITE	www.Acentraqio.com

DC

Livanta

CALL	1-888-396-4646 or TTY 711
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WEBSITE	https://www.livantaqio.cms.gov/en

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CALL	1-888-396-4646 or TTY 711
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WEBSITE	https://www.livantaqio.cms.gov/en

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WEBSITE	www.Acentraqio.com

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WEBSITE	www.Acentraqio.com

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CALL	1-877-588-1123 or TTY 711
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WEBSITE	https://www.livantaqio.cms.gov/en

IA

Livanta

CALL	1-888-755-5580 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

IL

Livanta

CALL	1-888-524-9900 or TTY 711
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WEBSITE	https://www.livantaqio.cms.gov/en

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Livanta

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WEBSITE	https://www.livantaqio.cms.gov/en

KS

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WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WEBSITE	www.Acentraqio.com

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CALL	1-888-315-0636 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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CALL	1-888-319-8452 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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CALL	1-888-396-4646 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

MN

Livanta

CALL	1-888-524-9900 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WEBSITE	www.Acentraqio.com

NE

Livanta

CALL	1-888-755-5580 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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CALL	1-888-319-8452 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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CALL	1-866-815-5440 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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CALL	1-888-315-0636 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

NV

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CALL	1-877-588-1123 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

NY

Livanta

CALL	1-866-815-5440 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

OH

Livanta

CALL	1-888-524-9900 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WEBSITE	www.Acentraqio.com

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WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

PA

Livanta

CALL	1-888-396-4646 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

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CALL	1-888-396-4646 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

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WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

WA

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CALL	1-888-305-6759 or TTY 711
WRITE	Acentra, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

WI

Livanta

CALL	1-888-524-9900 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

WV

Livanta

CALL	1-888-396-4646 or TTY 711
WRITE	BFCC-QIO Program, Livanta LLC, PO Box 2687, Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov/en

WY

Acentra

CALL	1-888-317-0891 or TTY 711
WRITE	Acentra, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.Acentraqio.com

Medicaid

AK

State of Alaska Department of Health & Social Services (Medicaid)

CALL	1-800-478-6065 or 1-907-269-3680
WRITE	State of Alaska Department of Health & Social Services, Division of Health Care Services, 3601 C Street, Suite 902, Anchorage, AK 99503-7167
WEBSITE	https://health.alaska.gov/en/division-of-health-care-services/

AL

Alabama Medicaid Agency

CALL	1-334-242-5000 or 1-800-362-1504 or TTY 1-800-253-0799
WRITE	Alabama Medicaid Agency, P.O. Box 5624, Montgomery, AL 36103-5624
WEBSITE	www.medicaid.alabama.gov

AR

Arkansas Medicaid

CALL	1-855-372-1084 or TTY 711
WRITE	Arkansas Medicaid, Department of Human Services, Donaghey Plaza, P.O. Box 1437, Little Rock, AR 72203
WEBSITE	https://access.arkansas.gov/Learn/HealthCare

AZ

Arizona Health Care Cost Containment System (AHCCCS) (Medicaid)

CALL	1-602-417-4000 or 1-800-654-8713
WRITE	Arizona Health Care Cost Containment System (AHCCCS), 801 E. Jefferson Street, Phoenix, AZ 85034
WEBSITE	https://www.azahcccs.gov

CA

Medi-Cal (Medicaid)

CALL	1-916-552-9200 or 1-800-541-5555
WRITE	Medi-Cal, P.O. Box 997417, MS 4607, Sacramento, CA 95899-7417
WEBSITE	https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

CO

Health First Colorado (Medicaid)

CALL 1-800-221-3943 or TTY 711

WRITE Health First Colorado, Department of Health Care Policy & Financing, 303 E. 17th Avenue, Suite 1100, Denver, CO 80203

WEBSITE https://www.healthfirstcolorado.com/

CT

Connecticut State Office of the Healthcare Advocate (Medicaid)

CALL 1-866-466-4446 or TTY 1-800-842-4524

WRITE Office of the Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144

WEBSITE https://portal.ct.gov/oha/health-care-plans/other-plans/medicaid

DC

Department of Health Care Finance (Washington, DC Medicaid)

CALL 1-202-442-5988 or 1-202-727-5355 or TTY 711

WRITE Department of Health Care Finance, 441 4th Street, NW, 900S, Washington, DC 20001

WEBSITE https://dhcf.dc.gov/service/medicaid

DE

Delaware Health & Social Services (Medicaid)

CALL 1-302-571-4900 or 1-866-843-7212

WRITE Delaware Health & Social Services, Division of Medicaid and Medical Assistance, DHSS Herman Holloway Campus, Lewis Building, 1901 N. DuPont Highway, New Castle, DE 19720

WEBSITE www.dhss.delaware.gov/dhss/dmma/

FL

Agency For Health Care Administration (Florida Medicaid)

CALL 1-877-711-3662 or TTY 1-866-467-4970

WRITE Agency For Health Care Administration, P.O. Box 5197, MS 62, Tallahassee, FL 32314

WEBSITE http://www.flmedicaidmanagedcare.com/

GA

Georgia Medicaid

CALL 1-404-657-5468 or 1-877-423-4746 or TTY 711

WRITE Georgia Medicaid, Georgia Department of Community Health, 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334

WEBSITE https://medicaid.georgia.gov

HI

Department of Human Services, MedQUEST Division (Hawaii Medicaid)

CALL 1-808-524-3370 (Oahu) or 1-800-316-8005 (Neighbor Islands) or TTY 711

WRITE Med-QUEST, P.O. Box 700190, Kapolei, HI 96709-0190

WEBSITE https://medquest.hawaii.gov/en/members-applicants/get-started.html

IA

Iowa Medicaid

CALL 1-515-256-4606 or 1-800-338-8366 or TTY 1-800-735-2942

WRITE Iowa Medicaid, Departmnent of Health and Human Services, Lucas Building, 321 East 12th Street, Des Moines, IA 50319

WEBSITE https://hhs.iowa.gov/programs/welcome-iowa-medicaid

ID

Idaho Department of Health and Welfare (Medicaid)

CALL 1-877-456-1233

WRITE Idaho Department of Health and Welfare, 3232 Elder Street, Boise, ID 83705

WEBSITE https://healthandwelfare.idaho.gov/services-programs/medicaid-health

IL

Illinois Department of Healthcare and Family Services (Medicaid)

CALL 1-800-843-6154 or TTY 1-800-447-6404

WRITE Illinois Department of Healthcare and Family Services, 401 South Clinton, Chicago, IL 60607

WEBSITE https://hfs.illinois.gov/medicalclients/medicalprograms.html

IN

Indiana Medicaid

CALL 1-800-457-4584 or TTY 711

WRITE Indiana Family & Social Services Administration, Division of Family Resources, Office of Medicaid Policy and Planning, 402 W. Washington Street, P.O. Box 7083, Indianapolis, IN 46207-7083

WEBSITE https://www.in.gov/medicaid/

KS

KanCare (Kansas Medicaid)

CALL 1-800-792-4884 or TTY 1-800-792-4292

WRITE KanCare, P.O. Box 3599, Topeka, KS 66601-9738

WEBSITE www.kancare.ks.gov/

KY

Cabinet for Health and Family Services (Kentucky Medicaid)

CALL 1-502-564-5497

WRITE Cabinet for Health and Family Services, Department for Medicaid Services, 275 East Main Street 6WA, Frankfort, KY 40621

WEBSITE https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx

LA

Louisiana Medicaid

CALL 1-888-342-6207

WRITE Louisiana Medicaid, Louisiana Department of Health, P.O. Box 629, Baton Rouge, LA 70821-0629

WEBSITE https://ldh.la.gov/index.cfm/subhome/1/n/331

MA

MassHealth (Medicaid)

CALL 1-800-841-2900 or TTY 711

WRITE MassHealth, 100 Hancock Street, First Floor, Quincy, MA 02171

WEBSITE https://www.mass.gov/orgs/masshealth

MD

Maryland Medicaid

CALL 1-410-767-6500 or 1-800-284-4510

WRITE Maryland Medicaid Administration, Maryland Department of Health, 201 W. Preston Street, Baltimore, MD 21201

WEBSITE https://health.maryland.gov/mmcp/Pages/home.aspx

ME

Office of MaineCare Services (Medicaid)

CALL 1-207-287-3707 or 1-800-977-6740 or TTY 711

WRITE Office of MaineCare Services, Department of Health and Human Services, 109 Capitol Street, 11 State House Station, Augusta, ME 04333

WEBSITE http://www.maine.gov/dhhs/oms/

MI

Michigan Medicaid

CALL 1-800-642-3195 or TTY 1-800-649-3777

WRITE Michigan Medicaid, Michigan Department of Health & Human Services, 333 South Grand Avenue, P.O. Box 30195, Lansing MI 48909

WEBSITE https://www.michigan.gov/mdhhs/assistance-programs/medicaid

MN

Minnesota Department of Human Services (Medicaid)

CALL 1-651-431-2670 or 1-800-657-3739 or TTY 711

WRITE Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155

WEBSITE https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

MO

MO HealthNet Division (Medicaid)

CALL 1-573-751-3425 or 1-800-392-2161 or TTY 1-800-735-2966 or 711

WRITE Missouri Dept of Social Services, MO HealthNet Division, 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-6500

WEBSITE https://mydss.mo.gov/mhd

MS

Mississippi Division of Medicaid

CALL 1-601-359-6050 or 1-800-421-2408

WRITE Mississippi Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201

WEBSITE www.medicaid.ms.gov

MT

Montana Medicaid

CALL 1-800-362-8312 or TTY 1-800-833-8503

WRITE Montana Medicaid, Montana Department of Public Health & Human Services, P.O. Box 202953, Helena, MT 59620-2953

WEBSITE https://www.dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices

NC

NC Medicaid

CALL 1-888-245-0179

WRITE NC Medicaid, Division of Health Benefits, 2501 Mail Service Center, Raleigh, NC 27699-2501

WEBSITE https://ncgov.servicenowservices.com/sp_beneficiary?id=bnf_learn

ND

North Dakota Health and Human Services (Medicaid)

CALL 1-701-328-7068 or 1-800-755-2604 or TTY 711

WRITE Medical Services Division, North Dakota Health and Human Services, 600 E. Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250

WEBSITE https://www.hhs.nd.gov/healthcare/medicaid

NE

Nebraska Department of Health and Human Services (Medicaid)

CALL 1-855-632-7633 or TTY 1-402-471-7256 or 1-800-833-7352

WRITE Nebraska Department of Health and Human Services, Medicaid Dept, 301 Centennial Mall S, Lincoln, NE 68508

WEBSITE https://dhhs.ne.gov/Pages/Medicaid-Eligibility.aspx

NH

NH Department of Health and Human Services (Medicaid)

CALL 1-844-275-3447 or TTY 1-800-735-2964

WRITE Division of Medicaid Services, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301

WEBSITE https://www.dhhs.nh.gov/programs-services/medicaid

NJ

NJ FamilyCare/Medicaid

CALL 1-800-701-0710 or TTY 711

WRITE NJ FamilyCare/Medicaid, NJ Department of Human Services, 222 South Warren Street, P.O. Box 700, Trenton, NJ 08625-0712

WEBSITE https://www.nj.gov/humanservices/dmahs/clients/medicaid/

NM

NM Human Services Department's Medical Assistance Division (Medicaid)

CALL 1-505-827-3100 or 1-800-283-4465

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

NV

Nevada Medicaid

CALL 1-800-992-0900 or 1-877-638-3472

WRITE Nevada Medicaid, Customer Service, P.O. Box 30042, Reno, NV 89520-3042

WEBSITE https://accessnevada.gov/public/landing-page

NY

New York State Medicaid

CALL 1-800-541-2831 or 1-855-355-5777 or TTY 1-800-662-1220

WRITE New York State Medicaid, New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237

WEBSITE www.health.ny.gov/health_care/medicaid/

OH

Ohio Department of Medicaid

CALL	1-800-324-8680 or TTY 1-800-292-3572
WRITE	Ohio Department of Medicaid, 50 West Town Street, Suite 400, Columbus, OH 43215
WEBSITE	http://medicaid.ohio.gov/

OK

SoonerCare (Oklahoma Medicaid)

CALL	1-405-522-7300 or 1-800-987-7767 or TTY 711
WRITE	SoonerCare, Oklahoma Health Care Authority, 4345 North Lincoln Boulevard, Oklahoma City, OK 73105
WEBSITE	https://www.oklahoma.gov/ohca.html

OR

Oregon Health Plan (Medicaid)

CALL	1-800-699-9075 or 1-800-273-0557 or TTY 711
WRITE	Oregon Health Plan, Medicaid Division, P.O. Box 14015, Salem, OR 97301-1097
WEBSITE	https://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx

PA

Pennsylvania Department of Human Services (Medicaid)

CALL	1-800-692-7462 or TTY 1-800-451-5886
WRITE	Pennsylvania Department of Human Services, Office of Medical Assistance Programs, P.O. Box 2675, Harrisburg, PA 17105-2675
WEBSITE	https://www.pa.gov/en/agencies/dhs/resources/medicaid.html

PR

Medicaid Program Department of Health (Puerto Rico Medicaid)

CALL	1-787-641-4224 or 1-787-765-2929 Ext. 6700 or TTY 1-787-625-6955
WRITE	Medicaid Program Department of Health, P.O. Box 70184 San Juan, PR 00936-8184
WEBSITE	https://www.medicaid.pr.gov/

RI

Rhode Island Executive Office of Health and Human Services (Medicaid)

CALL	1-855-840-4774 or TTY 711
WRITE	RI Executive Office of Health and Human Services, 3 West Road, Cranston, RI 02920
WEBSITE	https://eohhs.ri.gov/consumer/health-care

SC

South Carolina Healthy Connections Medicaid

CALL	1-888-549-0820 or TTY 1-888-842-3620
WRITE	SC Department of Health and Human Services, South Carolina Healthy Connections Medicaid, P.O. Box 8206, Columbia, SC 29202-8206
WEBSITE	https://www.scdhhs.gov

SD

South Dakota Department of Social Services (Medicaid)

CALL	1-605-773-3165
WRITE	South Dakota Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, SD 57501
WEBSITE	https://dss.sd.gov/medicaid/default.aspx

TN

TennCare (Medicaid)

CALL	1-800-342-3145 or 1-855-259-0701 or TTY 1-877-779-3103
WRITE	TennCare, 310 Great Circle Road, Nashville, TN 37243
WEBSITE	https://www.tn.gov/tenncare/members-applicants/eligibility/tenncare-medicaid.html

TX

Texas Health and Human Services (Medicaid)

CALL	1-800-335-8957 or 1-800-252-8263 or TTY 711 or 1-800-735-2989
WRITE	Texas Health and Human Services, P.O. Box 13247, Austin, Texas 78711-3247
WEBSITE	https://www.hhs.texas.gov/services/health/medicaid-chip

UT

Utah Medicaid

CALL 1-800-662-9651

WRITE Utah Medicaid, Department of Health and Human Services, Division of Integrated Healthcare, P.O. Box 143106, Salt Lake City, UT 84114-3106

WEBSITE https://medicaid.utah.gov/

VA

Virginia Medicaid

CALL 1-833-5CALLVA or TTY 1-888-221-1590

WRITE Department of Medical Assistance Services, Virginia Medicaid, 600 E. Broad Street, Richmond, VA 23219

WEBSITE https://www.dmas.virginia.gov/

VT

Green Mountain Care (Vermont Medicaid)

CALL 1-800-250-8427 or TTY 711

WRITE Green Mountain Care, Department of Vermont Health Access, 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010

WEBSITE https://dvha.vermont.gov/members/medicaid

WA

Washington Apple Health (Medicaid)

CALL 1-800-562-3022 or TTY 711

WRITE Washington Apple Health (Medicaid), Washington State Health Care Authority, P.O. Box 45531, Olympia, WA 98504

WEBSITE https://www.hca.wa.gov/free-or-low-cost-health-care

WI

Wisconsin Medicaid

CALL 1-800-362-3002 or TTY 711 or 1-800-947-3529

WRITE Wisconsin Medicaid, Department of Health Services, 1 West Wilson Street, Madison, WI 53703

WEBSITE https://dhs.wisconsin.gov/medicaid/index.htm

WV

West Virginia Bureau for Medical Services (Medicaid)

CALL 1-304-558-1700

WRITE West Virginia Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, WV 25301

WEBSITE www.dhhr.wv.gov/bms/Pages/default.aspx

WY

Wyoming Medicaid

CALL 1-307-777-7531 or 1-855-294-2127 or TTY 1-307-777-5648

WRITE Wyoming Medicaid, 122 W. 25th Street, 4th Floor West, Cheyenne, WY 82001

WEBSITE https://health.wyo.gov/healthcarefin/medicaid/

SPAP

DE

Chronic Renal Disease Program (CRDP)

CALL 1-302-424-7180 or 1-800-464-4357

WRITE Chronic Renal Disease Program (CRDP), Delaware Health and Social Services (DHSS), Milford Riverwalk, 253 NE Front Street, Riverwalk Shopping Center, Milford, DE 19963

WEBSITE www.dhss.delaware.gov/dhss/dmma/crdprog.html

Delaware Prescription Assistance Program

CALL 1-844-245-9580

WRITE DPAP, P.O. Box 950, New Castle, DE 19720

WEBSITE https://dhss.delaware.gov/dhss/dmma/dpap.html

IN

HoosierRx

CALL 1-866-267-4679

WRITE HoosierRx, 402 W. Washington, Room 372, Indianapolis, IN 46204

WEBSITE https://www.in.gov/medicaid/members/member-programs/hoosierrx/

MA

Prescription Advantage

CALL 1-800-243-4636 or TTY 1-877-610-0241

WRITE Prescription Advantage, P.O. Box 15153, Worcester, MA 01615-0153

WEBSITE https://www.prescriptionadvantagema.org/

MD

Maryland - SPDAP

CALL 1-800-551-5995 or TTY 1-800-877-5156

WRITE Maryland - SPDAP, c/o International Software Systems Inc., P.O. Box 749, Greenbelt, MD 20768-0749

WEBSITE http://marylandspdap.com

Maryland Kidney Disease Program

CALL 1-410-767-5000

WRITE Maryland Kidney Disease Program, 201 W. Preston Street, Room SS-3, Baltimore, MD 21201

WEBSITE https://health.maryland.gov/pha/Pages/maryland-kidney-disease-program.aspx

ME

Maine Rx Plus

CALL 1-866-796-2463 or 1-800-423-4331 or TTY 1-207-287-1828

WRITE Maine Rx Plus, Department of Health and Human Services, 109 Capitol Street, 11 State House Station, Augusta, ME 04333

WEBSITE https://www.payingforseniorcare.com/maine/drugs-for-elderly-rx-plus

MO

Missouri Rx (MORx)

CALL 1-800-375-1406 or TTY 1-800-375-1493

WRITE Missouri Rx (MORx), Missouri Dept of Social Services, MO HealthNet Division, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500

WEBSITE https://mydss.mo.gov/mhd/morx-general-faqs

MT

Big Sky Rx Program

CALL 1-866-369-1233 or TTY 711

WRITE Big Sky Rx Program, P.O. Box 202915, Helena, MT 59620-2915

WEBSITE https://dphhs.mt.gov/SLTC/aging/BigSky

Montana Mental Health Services Plan (MHSP)

CALL 1-406-444-3964

WRITE Montana Mental Health Services Plan (MHSP), Behavioral Health and Developmental Disabilities Division, P.O. Box 4210, Helena, MT 59620

WEBSITE https://dphhs.mt.gov/BHDD/mentalhealthservices/index

NJ

Pharmaceutical Assistance to the Aged and Disabled (PAAD)

CALL 1-800-792-9745

WRITE Pharmaceutical Assistance to the Aged and Disabled (PAAD), Division of Aging Services, New Jersey Department of Human Services, P.O. Box 715, Trenton, NJ 08625-0715

WEBSITE https://www.nj.gov/humanservices/doas/services/l-p/paad/

Senior Gold Prescription Discount Program

CALL 1-800-792-9745

WRITE Senior Gold Prescription Discount Program, Division of Aging Services, New Jersey Department of Human Services, P.O. Box 715, Trenton, NJ 08625-0715

WEBSITE https://nj.gov/humanservices/doas/services/q-z/senior-gold/

NM

New Mexico Medical Insurance Pool

CALL 1-866-306-1882

WRITE New Mexico Medical Insurance Pool, P.O. Box 780548, San Antonio, TX 78278

WEBSITE https://www.nmmip.org/

NY

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

CALL 1-800-332-3742 or TTY 1-800-290-9138

WRITE EPIC, P.O. Box 15018, Albany, NY 12212-5018

WEBSITE www.health.ny.gov/health_care/epic/

OK

Rx for Oklahoma Prescription Assistance

CALL 1-405-521-2828 or 1-800-763-2828 or TTY 711

WRITE Rx for Oklahoma Prescription Assistance, Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105

WEBSITE https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/low-income-subsidy-lis-for-prescription-drugs/

PA

Chronic Renal Disease Program (CRDP)

CALL 1-800-225-7223 or TTY 711

WRITE The Chronic Renal Disease Program, Pennsylvania Department of Health, Division of Child and Adult Health Services, Health and Human Services Building, 625 Forster Street, 7th Floor East Wing, Harrisburg, PA 17120-0701

WEBSITE https://www.pa.gov/agencies/health/diseases-conditions/chronic-disease/chronic-renal-disease.html

PACE Needs Enhancement Tier (PACENET)

CALL 1-800-225-7223 or TTY 711

WRITE PACE Needs Enhancement Tier (PACENET), P.O. Box 8806, Harrisburg, PA 17105-8806

WEBSITE https://www.pa.gov/agencies/aging/aging-programs-and-services/pace-program.html

Pharmaceutical Assistance Contract for the Elderly (PACE)

CALL 1-800-225-7223 or TTY 711

WRITE Pharmaceutical Assistance Contract for the Elderly (PACE), P.O. Box 8806, Harrisburg, PA 17105-8806

WEBSITE https://www.pa.gov/agencies/aging/aging-programs-and-services/pace-program.html

RI

Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)

CALL 1-401-462-3000 or 1-401-462-0560 or TTY 1-401-462-0740

WRITE Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE), Office of Healthy Aging, 25 Howard Avenue, Louis Pasteur Building #57, Cranston, RI 02920

WEBSITE https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance

TX

Kidney Health Care Program

CALL 1-512-776-7150 or 1-800-222-3986

WRITE Kidney Health Care Program, MC 1938, P.O. Box 149030, Austin, TX 78714-9947

WEBSITE https://www.hhs.texas.gov/services/health/chronic-kidney-disease/kidney-health-care

VT

Green Mountain Care Prescription Assistance

CALL 1-800-250-8427 or TTY 711

WRITE Green Mountain Care, Department of Vermont Health Access, 280 State Drive, NOB 1 South, Waterbury, VT 05671-8100

WEBSITE https://dvha.vermont.gov/members/prescription-assistance

WI

SeniorCare

CALL 1-800-657-2038 or TTY 711

WRITE SeniorCare, P.O. Box 6710, Madison, WI 53716-0710

WEBSITE https://dhs.wisconsin.gov/seniorcare/index.htm

Wisconsin Adult Cystic Fibrosis Program

CALL 1-800-362-3002

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

Wisconsin Chronic Renal Disease Program

CALL 1-800-362-3002

WRITE Wisconsin Chronic Renal Disease Program, P.O. Box 6410, Madison, WI 53716-0410

WEBSITE https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin Hemophilia Home Care Program

CALL 1-800-362-3002

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

ADAP

AK

Alaskan AIDS Assistance Association

CALL 1-907-263-2050 or 1-800-478-2437

WRITE Alaskan AIDS Assistance Association, 1057 W. Fireweed Lane, Suite 102, Anchorage, AK 99503

WEBSITE https://www.alaskanaids.org/client-services/aids-drug-assistance-program-adap

AL

Alabama AIDS Drug Assistance Program

CALL 1-866-574-9964

WRITE Alabama AIDS Drug Assistance Program, Office of HIV Prevention and Care, Alabama Department of Public Health, P.O. Box 303017, Montgomery, AL 36130-3017

WEBSITE http://www.alabamapublichealth.gov/hiv/adap.html

AR

Arkansas AIDS Drug Assistance Program

CALL 1-800-462-0599

WRITE Arkansas AIDS Drug Assistance Program, Arkansas Department of Health, 4815 W. Markham, Little Rock, AR 72205

WEBSITE https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/

AZ

Arizona AIDS Drug Assistance Program

CALL 1-602-364-3610 or 1-800-334-1540

WRITE Arizona AIDS Drug Assistance Program, Arizona Department of Health Services, 150 North 18th Avenue, Phoenix, AZ 85007

WEBSITE https://www.azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/index.php#aids-drug-assistance-program-home

CA

California AIDS Drug Assistance Program

CALL 1-916-558-1784

WRITE California AIDS Drug Assistance Program, CDPH, P.O. Box 997377, Mail Stop 0500, Sacramento, CA 95899

WEBSITE https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx

CO

Bridging the Gap - Colorado

CALL 1-303-692-2716

WRITE Bridging the Gap -Colorado, CDPHE Care and Treatment Program SDAP-3800, 4300 Cherry Creek Drive South, Denver, CO 80246-1530

WEBSITE https://cdphe.colorado.gov/state-drug-assistance-program

CT

Connecticut AIDS Drug Assistance Program

CALL 1-860-509-8000

WRITE Connecticut AIDS Drug Assistance Program, Connecticut Department of Public Health, 410 Capitol Avenue, Hartford, CT 06134

WEBSITE https://portal.ct.gov/dss/health-and-home-care/cadap/connecticut-aids-drug-assistance-program-cadap

DC

DC AIDS Drug Assistance Program

CALL 1-202-671-4815 or TTY 711

WRITE DC AIDS Drug Assistance Program, DC Health, 2201 Shannon Place SE, Washington, DC 20020

WEBSITE https://dchealth.dc.gov/DC%20Pharmacy%20Benefits%20Program

DE

Ryan White Program (Delaware AIDS Drug Assistance Program)

CALL 1-302-744-1000

WRITE Ryan White Program, Delaware Health & Social Services, Division of Public Health, Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901

WEBSITE https://www.dhss.delaware.gov/dph/dpc/hivtreatment.html

FL

Florida AIDS Drug Assistance Program

CALL 1-850-245-4422 or 1-844-381-2327 or TTY 1-888-503-7118

WRITE Florida AIDS Drug Assistance Program, Florida Department of Health, HIV/AIDS Section, 4052 Bald Cypress Way, BIN A09, Tallahassee, FL 32399

WEBSITE http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html

GA

Georgia AIDS Assistance Program

CALL 1-404-656-9805

WRITE Georgia AIDS Assistance Program, Georgia Department of Public Health, 200 Piedmont Avenue SE, Atlanta, GA 30334

WEBSITE https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap

HI

Hawaii AIDS Drug Assistance Program

CALL 1-808-733-9360

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/

IA

Ryan White Benefits and Drug Assistance Program (Iowa ADAP)

CALL 1-800-972-2017 or TTY 711 or 1-800-735-2942

WRITE Ryan White Benefits and Drug Assistance Program, Iowa Department of Health and Human Services, Lucas Building, 321 East 12th Street, Des Moines, IA 50319

WEBSITE https://hhs.iowa.gov/hiv-sti-and-hepatitis/hivaids-program

ID

Idaho AIDS Drug Assistance Program

CALL 1-208-334-5612 or 1-800-926-2588

WRITE Idaho AIDS Drug Assistance Program, Ryan White Part B Program, Dept. of Health & Welfare, 450 W. State Street, P.O. Box 83720, Boise, ID 83720-0036

WEBSITE https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv

IL

Illinois AIDS Drug Assistance Program

CALL 1-217-782-4977 or 1-800-325-3518 or TTY 1-800-547-0466

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

IN

Indiana AIDS Drug Assistance Program

CALL 1-866-588-4948

WRITE Indiana AIDS Drug Assistance Program, Indiana State Department of Health, 2 North Meridian Street, Suite 6C, Indianapolis, IN 46204

WEBSITE https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/

KS

Kansas AIDS Drug Assistance Program

CALL 1-785-296-1086

WRITE Kansas AIDS Drug Assistance Program, Kansas Department of Health and Environment, Division of Public Health, 1000 SW Jackson, Suite 540, Topeka, KS 66612

WEBSITE https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program-ADAP

KY

Kentucky AIDS Drug Assistance Program

CALL 1-502-564-6539 or 1-866-510-0005

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://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

LA

Louisiana Health Access Program (LA HAP)

CALL 1-504-568-7474

WRITE Louisiana Health Access Program (LA HAP), 1450 Poydras Street, Suite 2136, New Orleans, LA 70112

WEBSITE http://www.lahap.org/

MA

Massachusetts HIV Drug Assistance Program (HDAP)

CALL 1-617-502-1700 or 1-800-228-2714

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 https://crihealth.org/drug-assistance/hdap/

MD

Maryland AIDS Drug Assistance Program

CALL 1-410-767-6535 or 1-800-205-6308

WRITE Maryland AIDS Drug Assistance Program, Client Services, 1223 W. Pratt Street, Baltimore, MD 21223

WEBSITE https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx

ME

Maine AIDS Drug Assistance Program

CALL 1-207-287-3747 or TTY 711

WRITE Maine AIDS Drug Assistance Program, Department of Health and Human Services, 109 Capitol Street, 11 State House Station, Augusta, ME 04333

WEBSITE https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/ryan-white-b.shtml#adap

MI

Michigan Drug Assistance Program

CALL 1-888-826-6565

WRITE Michigan Drug Assistance Program, HIV Care Section, Division of HIV/STI Programs, Client and Partner Services, Bureau of HIV and STI Programs, Michigan Department of Health and Human Services, P.O. Box 30727, Lansing, MI 48909

WEBSITE https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program

MN

Minnesota AIDS Drug Assistance Program

CALL 1-651-431-2414 or 1-800-657-3761 or TTY 711

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

MO

Missouri AIDS Drug Assistance Program

CALL 1-888-252-8045

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

MS

Mississippi AIDS Drug Assistance Program

CALL 1-601-362-4879 or 1-888-343-7373

WRITE Mississippi AIDS Drug Assistance Program, Mississippi State Department of Health, Office of STD/HIV, P.O. Box 1700, Jackson, MS 39215-1700

WEBSITE http://msdh.ms.gov/msdhsite/_static/14,13047,150.html

MT

Montana AIDS Drug Assistance Program

CALL 1-406-444-3565

WRITE Montana AIDS Drug Assistance Program, Montana Department of Public Health and Human Services, HIV/STD Section, Cogswell Building, Room C211, 1400 Broadway, Helena, MT 59620-2951

WEBSITE https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog#:~:text=ADAP%20helps%20ensure%20that%20people,see%20the%20ADAP%20Pharmacy%20List.

NC

North Carolina HIV Medication Assistance Program (HMAP)

CALL 1-919-733-3419

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 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html

ND

North Dakota AIDS Drug Assistance Program

CALL 1-701-328-2378 or 1-800-472-2180

WRITE North Dakota AIDS Drug Assistance Program, North Dakota Department of Health, HIV/AIDS Program, 600 E. Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250

WEBSITE https://www.hhs.nd.gov/health/diseases-conditions-and-immunization/HIV/LivingwithHIV/RyanWhite

NE

Nebraska AIDS Drug Assistance Program

CALL 1-402- 471-3121 or TTY 1-800-833-7352

WRITE Nebraska AIDS Drug Assistance Program, Ryan White Program, NE Division of Public Health, Department of Health & Human Services, P.O. Box 95206, Lincoln, NE 68509-5026

WEBSITE https://dhhs.ne.gov/Pages/HIV-Care.aspx

NH

New Hampshire AIDS Drug Assistance Program

CALL 1-603-271-4496 or TTY 1-800-735-2964

WRITE New Hampshire AIDS Drug Assistance Program, Bureau of Infectious Disease Control, 29 Hazen Drive, Concord, NH 03301-3852

WEBSITE https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids

NJ

New Jersey AIDS Drug Distribution Program (ADDP)

CALL 1-877-613-4533 or 1-800-353-3232

WRITE New Jersey AIDS Drug Distribution Program (ADDP), New Jersey Department of Health, P.O. Box 360, Trenton, NJ 08625

WEBSITE https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml

NM

New Mexico AIDS Drug Assistance Program

CALL 1-833-796-8773

WRITE New Mexico AIDS Drug Assistance Program, NM Health, Harold Runnels Building, 1190 S. St. Francis Drive, Suite S-1200, Santa Fe, NM 87505

WEBSITE https://nmhealth.org/about/phd/idb/hats/

NV

Nevada AIDS Drug Assistance Program

CALL 1-702-526-4573

WRITE Nevada AIDS Drug Assistance Program, Ryan White Program, 2290 S. Jones Boulevard, Suite 110, Las Vegas, NV 89146

WEBSITE https://endhivnevada.org/ryan-white-care/

NY

New York AIDS Drug Assistance Program

CALL 1-844-682-4058 or 1-800-542-2437 or TTY 1-518-459-0121

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

OH

Ohio HIV Drug Assistance Program

CALL 1-800-777-4775

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/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program

OK

Oklahoma HIV Drug Assistance Program (HDAP)

CALL 1-405-271-5600 or 1-800-522-0203

WRITE Oklahoma HIV Drug Assistance Program (HDAP), Oklahoma State Department of Health, 123 Robert S. Kerr Ave., Suite 1702, Oklahoma City, OK 73102-6406

WEBSITE https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/prevention-and-preparedness/sexual-health-harm-reduction/provider-info/training-material/hiv-hdapbrochure14.pdf

OR

CAREAssist

CALL 1-971-673-0144 or TTY 711

WRITE CAREAssist, Oregon Health Authority, 800 NE Oregon Street, Suite 1105, Portland, OR 97232

WEBSITE https://www.oregon.gov/oha/PH/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/index.aspx

PA

Special Pharmaceutical Benefits Program

CALL 1-800-922-9384

WRITE Pennsylvania Department of Health, Special Pharmaceutical Benefits Program, P.O. Box 8808, Harrisburg, PA 17105-8808

WEBSITE https://www.pa.gov/agencies/health/diseases-conditions/infectious-disease/hiv/special-pharmaceutical-benefits.html

PR

Programa Ryan White Parte B/ADAP

CALL 1-787-765-2929 or 1-787-522-3954

WRITE Departamento de Salud, SASSI/SPCEIT, Programa Ryan White Parte B/ADAP, P.O. Box 70184, San Juan, PR 00936-8184

WEBSITE https://www.salud.pr.gov/CMS/137

RI

Rhode Island AIDS Drug Assistance Program

CALL 1-401-462-3295 or 1-401-462-5274

WRITE Rhode Island AIDS Drug Assistance Program, RI Executive Office of Health & Human Services, 3 West Road, Cranston, RI 02920

WEBSITE https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx

SC

South Carolina AIDS Drug Assistance Program

CALL 1-800-856-9954

WRITE South Carolina AIDS Drug Assistance Program, South Carolina Department of Public Health, 2100 Bull Street, Columbia, SC 29201

WEBSITE https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program

SD

Ryan White Part B CARE Program

CALL 1-605-773-3737 or 1-800-592-1861

WRITE Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th Street, Pierre, SD 57501-1700

WEBSITE https://doh.sd.gov/topics/disease-prevention-services/hivaids/ryan-white-part-b-program/

TN

Tennessee Ryan White Part B Program

CALL 1-615-532-2392

WRITE Tennessee Ryan White Part B Program, Tennessee Department of Health, 710 James Robertson Parkway, Nashville, TN 37243

WEBSITE https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html

TX

Texas HIV Medication Program

CALL 1-800-255-1090

WRITE Texas HIV Medication Program, MSJA, MC 1873, P.O. Box 149347, Austin, TX 78714-9347

WEBSITE http://www.dshs.texas.gov/hivstd/meds/

UT

Utah AIDS Drug Assistance Program

CALL 1-801-538-6191

WRITE Utah AIDS Drug Assistance Program, Utah Department of Health & Human Services, Cannon Health Building, 288 N 1460 W, Salt Lake City, UT 84116

WEBSITE https://epi.utah.gov/ryan-white/

VA

Virginia Medication Assistance Program (VA MAP)

CALL 1-855-362-0658 or TTY 711

WRITE Virginia Medication Assistance Program (VA MAP) Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219

WEBSITE https://www.vdh.virginia.gov/disease-prevention/eligibility/

VT

Vermont Medication Assistance Program (VMAP)

CALL 1-802-951-4005 or 1-800-464-4343

WRITE Vermont Medication Assistance Program (VMAP), Vermont Department of Health, 108 Cherry Street, P.O. Box 70, Burlington, VT 05402-0070

WEBSITE https://www.healthvermont.gov/disease-control/hiv/hiv-care

WA

Early Intervention Program (EIP)

CALL 1-360-236-3426 or 1-877-376-9316

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/early-intervention-program

WI

Wisconsin AIDS/HIV Drug Assistance Program

CALL	1-608-267-6875 or 1-800-991-5532
WRITE	Wisconsin AIDS/HIV Drug Assistance Program, Wisconsin Division of Public Health, Attn: ADAP, P.O. Box 2659, Madison, WI 53701-2659
WEBSITE	https://www.dhs.wisconsin.gov/hiv/hdap-clients.htm

WV

West Virginia AIDS Drug Assistance Program

CALL	1-304-232-6822
WRITE	West Virginia AIDS Drug Assistance Program, Attn: Jay Adams - HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003
WEBSITE	https://oeps.wv.gov/rwp/pages/default.aspx#adap

WY

Wyoming Communicable Disease Treatment Program

CALL	1-307-777-6563 or 1-866-571-0944
WRITE	Wyoming Communicable Disease Treatment Program, Wyoming Department of Health, 401 Hathaway Building, Cheyenne, WY 82002
WEBSITE	https://health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-program/hiv-treatment-resources-for-patients/

HealthSpring True Choice Core (PPO) Customer Service

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 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours. 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 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, holidays and after hours.
Fax	1-888-281-7867
Write	HealthSpring Attn: Medicare Customer Service PO Box 1002 Nashville, TN 37202
Website	www.HealthSpring.com/GroupMA

The State Health Insurance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Refer to Appendix A of this book for contact information.

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