Evidence of coverage

January 1 - December 31, 2024

Your Medicare Health Benefits Services, and Prescription Drug Coverage as a Member of Cigna True Choice Medicare (PPO)

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

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

This plan, Cigna True Choice Medicare (PPO), is offered by Cigna Healthcare. (When this *Evidence of Coverage* says "we," "us," or "our," it means Cigna Healthcare. When it says "plan" or "our plan," it means Cigna True Choice 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 copayments/coinsurance may change on January 1, 2025.

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

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

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

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

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

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

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

Cigna True Choice Medicare (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.

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

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

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

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

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

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

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

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

Section 2.1 Your eligibility requirements

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

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

Section 2.2 Here is the plan service area for our plan

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

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

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

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

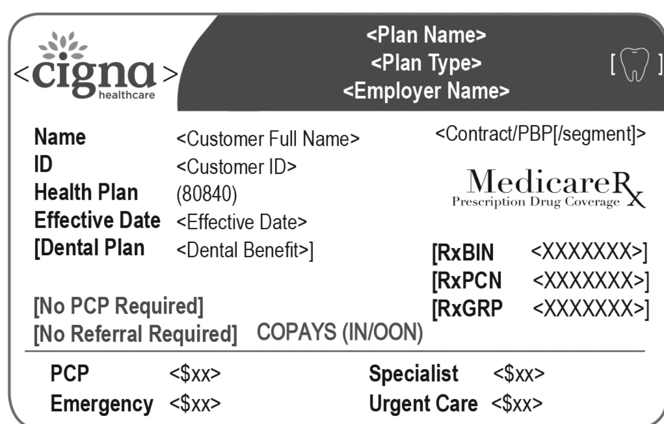
Section 2.3 U.S. Citizen or Lawful Presence

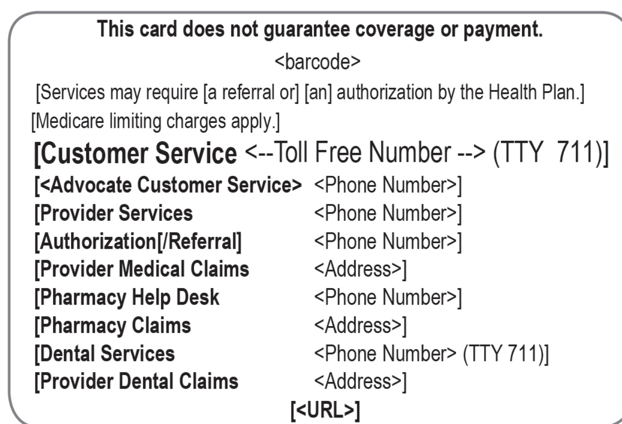
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Cigna True Choice Medicare (PPO) if you are not eligible to remain a member on this basis. Cigna True Choice Medicare (PPO) must disenroll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

SECTION 3 Important membership materials.

Section 3.1 Your plan membership card

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





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

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

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

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

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

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

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a List of Covered Drugs (Formulary). We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Cigna Rx Medicare (PDP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Cigna Rx Medicare (PDP) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

The Drug List we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (cignamedicare.com/group/maresources) or call Customer Service.

SECTION 4 Your monthly costs for your plan

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)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

In some situations, your plan premium could be less

If you are already enrolled and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2024 handbook, the section called "2024 Medicare Costs." If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

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

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

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

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

You will not have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

Note: Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.

Note: The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount was $32.74. This amount may change for 2024.

To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

First, the penalty may change each year, because the average monthly premium can change each year.

Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.

Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review within 60 days from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional

IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium.

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

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

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

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, your plan sponsor will tell you and the change will take effect on January 1. However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra

Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

Let us know about these changes:

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

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

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

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires us to collect information from you about any other medical insurance coverage and/or drug insurance coverage that you may have. This is because we must coordinate any other coverage you have with your benefits under our plan.

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

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

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

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

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:
Important phone numbers and resources

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

How to contact our plan's Customer Service

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

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

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

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

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

Method	Appeals for Medical Care - Contact Information
CALL	1-800-511-6943 Calls to this number are free. Hours are Monday – Friday, 7:00 a.m. – 9:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Calls to this number are free. Hours are Monday – Friday, 7:00 a.m. – 9:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
FAX	1-855-350-8671
WRITE	Cigna Healthcare, Attn: Part C Appeals, P.O. Box 188081, Chattanooga, TN 37422
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

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

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage*

decisions, appeals, complaints)).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
FAX	1-866-845-7267
WRITE	Cigna Healthcare, Attn: Coverage Determination & Exceptions, 8455 University Place #HQ2L-04, St. Louis, MO 63121
WEBSITE	www.cignamedicare.com/group/maresources

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. *Messaging service used weekends, after hours, and on federal holidays.*
FAX	1-866-593-4482
WRITE	Cigna Healthcare, Attn: Medicare Clinical Appeals, P.O. Box 66588, St. Louis, MO 63166-6588
WEBSITE	www.cignamedicare.com/group/maresources

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

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

Method	Payment Requests – Contact Information
WRITE	**Part C (Medical Services)** Cigna Healthcare Attn: Direct Member Reimbursement - Medical Claims P.O. Box 20002 Nashville, TN 37202 **Part D (Prescription Drugs)** Attn: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718
WEBSITE	cignamedicare.com/group/maresources

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on **"Talk to Someone"** in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

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

A QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. A QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in any of these situations:

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

SECTION 5 Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

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

SECTION 6 Medicaid

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

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

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

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

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-thecoverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out -of-pocket costs.

Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help", call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Appendix C for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please contact Customer Service to request assistance or to provide one of the documents listed below to establish your correct copay level. Please note that any document listed below must show that you were eligible for Medicaid during a month after June of the previous year:
  1. A copy of your Medicaid card which includes your name, eligibility date and status level;
  2. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status;
  3. A copy of a state document that confirms active Medicaid status;
  4. A printout from the State electronic enrollment file showing Medicaid status;
  5. A screen print from the State's Medicaid systems showing Medicaid status;
  6. Other documentation provided by the State showing Medicaid status;
  7. A Supplemental Security Income (SSI) Notice of Award with an effective date; or
  8. An Important Information letter from the Social Security Administration (SSA) confirming that you are "..automatically eligible for "Extra Help"..."
- If you are a member that is institutionalized, please provide one or more of the following:
  1. A remittance from a long-term care facility showing Medicaid payment for a full calendar month;
  2. A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar month on your behalf;
  3. A screen print from the State's Medicaid systems showing your institutional status based on at least a full calendar month's stay for Medicaid payment purposes.
  4. For Individuals receiving home and community based services (HCBS), you may submit a copy of:
     a. A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;

b. A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

c. A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,

e. A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

- You can also visit the CMS website: www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/ best_ available_ evidence_ policy.html to find out more. When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you.

  Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. If you reach the coverage gap stage, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts toward your out-of-pocket costs and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug. If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under- insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state's AIDS Drug Assistance Program (ADAP) refer to Appendix E.

SECTION 8 How to contact the Railroad Retirement Board

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

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

SECTION 9 Do 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's or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3:
Using the plan for your medical services

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

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

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

Section 1.1 What are "network providers" and "covered services"?

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

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

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

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

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

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

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

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

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

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

- General Practitioner
- Family medicine
- Internal medicine
- Geriatrics

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

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

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

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

How do you choose your PCP?

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

Changing your PCP

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

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

Section 2.2 What kinds of medical care can you get without getting a referral from your PCP?

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

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

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

- Oncologists care for patients with cancer.

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

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

Prior authorization may be needed for certain services (please see the *Evidence of Coverage Snapshot* for information which services require prior authorization). Authorization can be obtained from the plan. You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

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

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

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

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

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

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in

Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are 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. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* 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 Getting care when you have urgent need for services

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out-of-network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

Section 3.3 Getting care during a disaster

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

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

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

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

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

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

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

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

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

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

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

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

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

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

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

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

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at:

www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

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

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

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

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

Medicare Inpatient Hospital coverage limits apply (please refer to the Medical Benefits Chart in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for oxygen equipment, supplies, and maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, our plan will cover:

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

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

Section 8.2 What is your cost-sharing? Will it change after 36 months?

Your cost-sharing for Medicare oxygen equipment coverage is the coinsurance or copayment amount listed for durable medical equipment (DME) in the Medical Benefits Chart that appears in Chapter 4, every month that you require oxygen equipment while enrolled in our plan.

If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is the coinsurance or copayment amount listed for Durable medical equipment (DME) in the Medical Benefits Chart that appears in the *Evidence of Coverage Snapshot,* every month that you require oxygen equipment while enrolled in our plan.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

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

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

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

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

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

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

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

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

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

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

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

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

Here is how this protection works.

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

SECTION 2 Use the Medical Benefits Chart found in the *Evidence of Coverage Snapshot* to find out what is covered and how much you will pay

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

The Medical Benefits Chart on the *Evidence of Coverage Snapshot* that we mailed to you lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

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

Other important things to know about our coverage:

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

SECTION 3 What services are not covered by the plan?

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

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

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

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

CHAPTER 5:
Using the plan’s coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 5, Section 9 for Medicare Part B drug benefits in special situations for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are on the plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Provider and Pharmacy Directory, visit our website (cignamedicare.com/group/maresources), or call Customer Service.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Service or use the Provider and Pharmacy Directory. You can also find information on our website at cignamedicare.com/group/maresources.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should rarely happen.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Customer Service.

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order up to a 90-day supply.

You may go to any of our network mail-order pharmacies.

To get information about filling your prescriptions by mail, please visit our website (cignamedicare.com/group/maresources) or contact Customer Service.

Usually a mail-order pharmacy order will get to you in no more than 14 days. In the event a mail order package is delayed, the mail-order pharmacy will assist you to coordinate a short-term fill with a retail pharmacy that is near you. You can also contact Customer Service for assistance.

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling 1-877-860-0982 (TTY 711) or by logging in to myCigna.com.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-877-860-0982 (TTY 711) or by logging in to myCigna.com.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 15 days before your current prescription will run out. This will ensure your order is shipped to you in time. To opt out of our program that automatically prepares mail order refills, please contact us by calling 1-877-860-0982 (TTY 711) or by logging in to myCigna.com.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you will be responsible for the difference in price. Your Provider and Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You travel outside the plan's service area and run out of or lose covered Part D drugs, or become ill and need a covered Part D drug and cannot access a network pharmacy.
- You are unable to obtain a covered Part D drug in a timely manner within the service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24/7 service.
- You are filling a prescription for a covered Part D drug and that particular drug is not regularly stocked at an accessible network retail or mail order pharmacy.
- The Part D drugs are dispensed by an out-of-network institution-based pharmacy while in an emergency facility, provider-based clinic, outpatient surgery, or other outpatient setting.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost-share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a *"List of Covered Drugs (Formulary)."* In this *Evidence of Coverage*, **we call it the "Drug List" for short**. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- — *or* — Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes both brand name and generic drugs

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, generics work just as well as the brand name drug and usually cost less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).

- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. For more information, please see Chapter 9.

Section 3.2 There are 5 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Tier	Includes	Helpful Tips
Teir 1: Preferred Generic Drugs	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	This grouping of prescription drugs represents the lowest cost-sharing.
Teir 2: Generic Drugs	This tier includes preferred brand-name drugs as well as some generic drugs.	Drugs in Tier 2 generally have a lower cost-share amount than those in the non-preferred tier.
Tier 3: Preferred Drugs	This tier includes preferred brand-name as well as some generic drugs.	Drugs in Tier 3 generally have a lower cost share than Tier 4. Drugs in this tier have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower cost drug may be right for you.
Tier 4: Non-Preferred Drugs	This tier includes non-preferred brand-name and non-preferred drugs not in a preferred tier.	Drugs in Tier 4 may have lower-cost alternatives in Tiers 1-3. Ask your doctor if switching to a lower cost drug may be right for you.
Tier 5: Specialty Drugs	This tier includes the highest cost brand-name and generic drugs.	To learn more about medications in this tier, you may contact your pharmacist or prescriber.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in the *Evidence of Coverage Snapshot*.

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Visit the plan's website (cignamedicare.com/group/maresources). The Drug List on the website is always the most current.
2. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once on our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost-sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid, etc.).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Services to learn what you or your provider would need to do to get coverage for the drug.

If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy**."

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way.**

- **If you are a new member** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**
  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- **In order to accommodate unexpected transitions of members without time for advanced planning, such as level-of-care changes due to discharge from a hospital to a nursing facility or to a home, we will cover a temporary 30-day supply.**

For questions about a temporary supply, call Customer Service.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If you drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Tier) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change — even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Sometimes, a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to drugs on the Drug List that that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on your use of the drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are not covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we will pay or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility

- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, if you are receiving "**Extra Help**" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filing a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group please contact **that group's benefits administrator**. Your group's benefits administrator can help you determine how your other prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be secondary to your group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "**creditable**."

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about these programs, please contact Customer Service.

CHAPTER 6:
What you pay for Part D prescription drugs

SECTION 1 Introduction

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter, along with the *Evidence of Coverage Snapshot*, focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs — some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost-sharing**, and there are three ways you may be asked to pay. Refer to your *Evidence of Coverage Snapshot* for more information.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules that we must follow when we keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

<u>Your out-of-pocket-costs include</u> the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage, if your plan has one
  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for our plan members?

There are four "drug payment stages" for your prescription drug coverage under our plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *Part D Explanation Benefits* (Part D EOB). The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports.

SECTION 4 Deductible information for our plan

If there is a deductible for our plan, you will begin in this stage when you fill your first covered Part D prescription of the year. You will pay the full cost of your drugs until you reach the deductible amount. Refer to the *Evidence of Coverage Snapshot* to see if your plan has a deductible.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your copayment or coinsurance amount. Your share of the cost will vary depending on the drug and where you fill your prescription. Refer to the *Evidence of Coverage Snapshot* to see what your share of the cost will be.

The plan has 5 cost-sharing tiers

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier	Includes	Helpful Tips
Teir 1: Preferred Generic Drugs	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	This grouping of prescription drugs represents the lowest cost-sharing.
Teir 2: Generic Drugs	This tier includes preferred brand-name drugs as well as some generic drugs.	Drugs in Tier 2 generally have a lower cost-share amount than those in the non-preferred tier.
Tier 3: Preferred Drugs	This tier includes preferred brand-name as well as some generic drugs.	Drugs in Tier 3 generally have a lower cost share than Tier 4. Drugs in this tier have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower cost drug may be right for you.
Tier 4: Non-Preferred Drugs	This tier includes non-preferred brand-name and non-preferred drugs not in a preferred tier.	Drugs in Tier 4 may have lower-cost alternatives in Tiers 1-3. Ask your doctor if switching to a lower cost drug may be right for you.
Tier 5: Specialty Drugs	This tier includes the highest cost brand-name and generic drugs.	To learn more about medications in this tier, you may contact your pharmacist or prescriber.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost-sharing.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Provider and Pharmacy Directory*.

Section 5.2 The *Evidence of Coverage Snapshot* shows your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or a coinsurance. As shown in the *Evidence of Coverage Snapshot*, the amount of the copayment or coinsurance depends on which cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price of the drug instead of the copayment.

As shown in the *Evidence of Coverage Snapshot*, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. If you plan has a Part D deductible, this will apply even if you haven't paid your deductible. If your insulin is on a tier where cost-sharing is lower than $35, you will pay the lower cost for your insulin.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

Section 5.4 The *Evidence of Coverage Snapshot* that shows your costs for a long-term 90-day supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply. The *Evidence of Coverage Snapshot* shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.
- You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if your plan has a deductible and you have not paid it.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

Refer to your *Evidence of Coverage Snapshot* to see what you will pay during the Coverage Gap Stage.

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. Refer to your Evidence of Coverage Snapshot to see what you will pay during the Coverage Gap Stage. You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount, $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage. Medicare has rules about what counts and what does not count as your out-of-pocket costs.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost of your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs. Refer to the *Evidence of Coverage Snapshot* to see what you will pay during the Catastrophic Coverage Stage.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. Call Customer Service for more information.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine medication itself.
- The second part of coverage is for the cost of giving you the vaccine. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**

   Most adult Part D vaccinations are recommended by ACIP and cost you nothing
2. **Where you get the vaccine**.
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine**.
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you will have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. Below are three examples of ways you might get a Part D vaccine:

Situation 1: You get your vaccination at the pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will have to pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

CHAPTER 7:
Asking us to pay our share of a bill you have received for covered medical services

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

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

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

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

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

4. **When you use an out-of-network pharmacy to get a prescription filled**
   If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.
5. **When you pay the full cost for a prescription because you don't have your plan membership card with you**
   If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
6. **When you pay the full cost for a prescription in other situations**

   You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
   - For example, the drug may not be on the plan's "Drug List" or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* has information about how to make an appeal.

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

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website, cignamedicare.com/group/maresources (Customer Forms) 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

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

For Part D (Prescription Drugs) Claims

Cigna Healthcare
Attn: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

You must submit your claim to us within 12 months for medical services or items or 3 years for prescription drugs of the date you received the service, item, or drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet).

If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the medical care or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the medical care or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical care covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your right to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Chapter 9 Section 4. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal."

Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Chapter 9 Section 5.3.
- If you want to make an appeal about getting paid back for a drug, go to Chapter 9 Section 6.5.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**

   Sometimes when you are in the Coverage Gap Stage you can buy your drug at a network pharmacy for a price that is lower than our price.

   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- Please note: If you are in the Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- Please note: Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly. Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions.

Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8:
Your rights and responsibilities

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

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

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

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

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

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

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

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

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

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

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

You have the right to choose a provider in the plan's network.

You also have the right to get non-emergency care after your PCP's office is closed. If you need to talk with your PCP or get medical care when the PCP office is closed, and it is *not* a medical emergency, call the PCP at the phone number found on your membership card. There is always a doctor on call to help you. The Telecommunications Relay Service (TRS) provides a relay service for deaf, hard-of-hearing and/or persons with speech and language disorders by dialing 711. The TRS will assist you in contacting your PCP.

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

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

Cigna Healthcare's Evaluation of New Technologies

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

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

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

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also

includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.** For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*.
  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at cignamedicare.com/group/maresources.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)* and the *Formulary Addendum* we mailed to you. These chapters, together with the *List of Covered Drugs (Formulary)* and the *Formulary Addendum*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service.
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

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

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help customers manage their medications and use drugs safely.
- **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. You also have the right to stop taking your medication. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint 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 to ask us to reconsider decisions we have made

If you have any problems, concerns or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we are required to treat you fairly.** You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service.

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

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

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the *Evidence of Coverage Snapshot* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:
What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

To make things easier, this chapter:

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP).

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. 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 were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

In limited circumstances an appeal request 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 an appeal request, we will 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, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

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

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

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

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 8** of this chapter: "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 section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.

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

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

This section is about your benefits for medical care and services. These benefits are described on the *Evidence of Coverage Snapshot*. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

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

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

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

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

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

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

  If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.

  If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a standard 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, Section 1 specifically 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 will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drugs**, we will give you an answer **within 72 hours** after we receive your request.

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

For fast coverage decisions we use an expedited timeframe.

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

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

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 are going on to Level 1 of the appeals process.

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

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

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

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

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

Step 2: Ask our plan for a Standard Appeal or a Fast Appeal.

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2, Section 1 specifically has contact information.

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

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 of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

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

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

- **If the 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 receive the decision from the independent review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the independent review organization for **standard requests. For expedited requests**, we have **24 hours** from the date we receive the decision from the independent 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 should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent independent review organization will send you a letter:
    - Explaining its decision.
    - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Telling you how to file a Level 3 appeal.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "Drug List" instead of "List of Covered Drugs" or "Formulary."

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover them.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Legal Terms
An initial coverage decision about your Part D drugs is called a "**coverage determination**."

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.
This section tells you how to ask for coverage decisions, including exceptions and how to request an appeal.

Section 6.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception.**"

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4, the Non-Preferred Drug Tier. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction on our coverage for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a biological product you can ask us to cover your drug at lower cost-sharing amount. This would be the lowest tier cost that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand name or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5, the Specialty Drug Tier.
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Terms
A "fast coverage decision" is called an "**expedited coverage determination**."

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

"Standard coverage decisions" are made within **72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision." To get a fast coverage decision, you must meet two requirements.

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.
- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received*.

Step 2: Request a "standard coverage decision" or a "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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 section 1 specifically has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement"** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider you request and we give you our answer.

Deadline for a "fast coverage decision"

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your prescriber's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 24 hours** after we receive your request or prescriber's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within **14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you decide if you want to make an 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 drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.5 Step-by-step: How to make a Level 1 Appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan "**redetermination**." A "fast appeal" is also called an "**expedited redetermination**."

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

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal."

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request or call us.** Chapter 2, Section 1 specifically has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-888-281-7867**. Refer to Chapter 2 **Appeals for Medical Care** for contact information.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request. Coverage requests involving prescription drugs can also be submitted electronically on our website at cignamedicare.com/group/maresources.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information**. You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

Step 4: **If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 appeal

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

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

Step 1: **You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
  - If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: **The independent review organization reviews your appeal.**

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast appeal"

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard appeal"

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For "fast appeals":

- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage within 24 hours after we receive the decision from the independent review organization.

For "standard appeals":

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we receive the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3,4 and 5 of the appeal process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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

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

Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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

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

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

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

Step 1: **Contact the Quality Improvement Organization (see Appendix B) for your state and ask for an immediate review of your hospital discharge. You must act quickly.**

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
  - If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 5.2.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 7.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

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

If the 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 wish to continue with the review process.

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

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

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

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

Section 8.2 We will tell you in advance when your coverage will be ending

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

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

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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

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

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

Act quickly:

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

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 5.2.

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

Legal Terms

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, 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 (refer to Appendix B) again and ask for another review.

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

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

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

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

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

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

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

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

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

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continue to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

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

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

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

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

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

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

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

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

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

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

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

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

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

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

- A judge will review all of the information and 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 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 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 have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information?

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

Section 10.2 How to make a complaint

Legal Terms

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

Section 10.3 Step-by-step: Making a complaint

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

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

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

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

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization (refer to Appendix B).**
  - 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.
- **You can make your complaint to both the Quality Improvement Organization and us by contacting Customer Service at the numbers found on the back of this booklet at the same time.**

Section 10.5 You can also tell Medicare about your complaint

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

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave.
  - Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

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

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

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

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

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

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

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

Who is eligible for a Special Enrollment Period?

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

- Usually, when you have moved.
- If you have Medicaid.

- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

  Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

When are Special Enrollment Periods? The Special Enrollment Periods vary depending on your situation.

- What can you do? To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.
  - Original Medicare without a separate Medicare prescription drug plan.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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

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

If you have any questions or would like more information on when you can end your membership:

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

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

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- Contact your plan sponsor and tell them you want to disenroll in the plan.
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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

If you would like to switch from our plan to:	This is what you would do:
Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare without a separate Medicare prescription drug plan. **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Send your plan sponsor a written request to disenroll.** • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

- If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.
- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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

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

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

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

- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

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

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

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

What should you do if you feel that this has happened?

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10 for information about how to make a complaint.

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

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

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help. Customer Service phone numbers are found on the back page of this booklet.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Notice about subrogation and third party recovery

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

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

1. Any award, settlement, benefits or other amounts paid under any workers' compensation law or award;
2. Any and all payments made directly by or on behalf of a third party tortfeasor or person, entity or insurer responsible for indemnifying the third party tortfeasor;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

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

1. Fully responding to requests for information about any accidents or injuries;
2. Fully responding to our requests for information and providing any relevant information that we have requested; and
3. Fully participating in all phases of any legal action we may need to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

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

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

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

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

If you disagree with any decision or action we take in connection with the subrogation and third party recovery provisions outlined above, you must follow the procedures explained in Chapter 7 of this booklet: What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

SECTION 5 Report Fraud, Waste and Abuse

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

CHAPTER 12:
Definitions of Important words

Chapter 12. Definitions of important words

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

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

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

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

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $8,000 in covered drugs during the covered year.

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

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

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

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

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

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

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

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, include 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.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

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

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

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

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

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

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

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

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out 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. We must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services, as well as the supplemental benefits we offer.

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

Income-Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs, including amounts you have paid and what your plan has paid on your behalf for the year, have reached $5,030.

Independent Physician Association (IPA) – An Independent Physician Association is a group of primary and specialty physicians.

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

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network providers. After you have reached this limit, you will not 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 provider. See Chapter 4, Section 1.2 for information about your in-network maximum out-of-pocket amount.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

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

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

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

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

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Medicare Part D. We may or may not offer all Part D drugs. (See your Drug List for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

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 are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network providers and a higher limit on your total combined out-of-pocket costs for services from both network and out-of-network providers.

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

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. In many Medicare health plans, you must see your primary care physician before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Evidence of Coverage Snapshot instead of Benefits Chart in CHapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are 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.

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

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

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

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

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

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

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

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

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

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

APPENDIX

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

Alabama

Alabama State Health Insurance Assistance Program

CALL 1-800-243-5463

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

WEBSITE www.alabamaageline.gov

Alaska

State Health Insurance Assistance Program

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

TTY 1-800-770-8973

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

WEBSITE http://medicare.alaska.gov

Arizona

State Health Insurance Assistance Program

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

TTY 711.0

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

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

Arkansas

Senior Health Insurance Information Program (SHIIP)

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

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

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

California

Health Insurance Counseling & Advocacy Program (HICAP)

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

TTY 1-800-735-2929

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

WEBSITE https://cahealthadvocates.org/hicap/

Colorado

Senior Health Insurance Assistance Program

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

TTY 1-303-894-7880

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

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

Connecticut

CHOICES

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

TTY 1-800-842-4524

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

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

Delaware

Delaware Medicare Assistance Bureau (DMAB)

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

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

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

District of Columbia

Health Insurance Counseling Project (HICP)

CALL 1-202-727-8370

TTY 711.0

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

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

Florida

SHINE (Serving Health Insurance Needs of Elders)

CALL 1-800-963-5337

TTY 1-800-955-8771

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

WEBSITE www.floridashine.org

Georgia

GeorgiaCares

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

TTY 1-404-657-1929

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

WEBSITE www.mygeorgiacares.org/

Hawaii

Hawaii SHIP

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

TTY 1-866-810-4379

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

WEBSITE www.hawaiiship.org/

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)

CALL 1-800-247-4422

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

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

Illinois

Senior Health Insurance Program (SHIP)

CALL 1-800-252-8966

TTY 1-888-206-1327

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

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

Indiana

State Health Insurance Assistance Program (SHIP)

CALL 1-800-452-4800

TTY 1-866-846-0139

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

WEBSITE www.medicare.in.gov

Iowa

Senior Health Insurance Information Program (SHIIP)

CALL 1-800-351-4664

TTY 1-800-735-2942

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

WEBSITE https://shiip.iowa.gov/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)

CALL 1-800-860-5260

TTY 1-785-291-3167

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

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

Kentucky

State Health Insurance Assistance Program

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

TTY 1-800-648-6056

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

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

Louisiana

Senior Health Insurance Information Program (SHIIP)

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

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

WEBSITE www.ldi.la.gov/SHIIP/

Maine

Maine State Health Insurance Program (SHIP)

CALL 1-800-262-2232

TTY 711.0

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

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

Maryland

Senior Health Insurance Assistance Program

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

TTY 711.0

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

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

Massachusetts

Serving the Health Insurance Needs of Everyone (SHINE)

CALL 1-800-243-4636

TTY 711.0

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

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

Michigan

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

CALL 1-800-803-7174

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

WEBSITE www.mmapinc.org/

Minnesota

Minnesota State Health Insurance Assistance

CALL 1-800-333-2433

TTY 1-800-627-3529

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

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

Mississippi

State Health Insurance Assistance Program (SHIP)

CALL 1-601-359-4500

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

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

Missouri

CLAIM - State Health Insurance Assistance Program

CALL 1-800-390-3330

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

WEBSITE www.missouriclaim.org

Montana

Montana State Health Insurance Assistance Program (SHIP)

CALL 1-800-551-3191

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

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

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)

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

TTY 1-800-833-7352

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

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

Nevada

State Health Insurance Assistance Program

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

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

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

New Hampshire

ServiceLink Aging & Disability Resource Center

CALL 1-866-634-9412

TTY 1-800-735-2964

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

WEBSITE www.nh.gov/servicelink/

New Jersey

State Health Insurance Assistance Program (SHIP)

CALL 1-800-792-8820

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

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

New Mexico

Aging & Disability Resource Center (ADRC)

CALL 1-800-432-2080

TTY 1-505-476-4937

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

WEBSITE www.nmaging.state.nm.us

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)

CALL 1-800-701-0501

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

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

North Carolina

Seniors' Health Insurance Information Program (SHIIP)

CALL 1-855-408-1212

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

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

North Dakota

State Health Insurance Counseling Program (SHIC)

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

TTY 1-800-366-6888

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

WEBSITE www.nd.gov/ndins/shic/

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)

CALL 1-800-686-1578

TTY 1-614-644-3745

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

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

Oklahoma

Senior Health Insurance Counseling Program (SHIP)

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

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

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

Oregon

Senior Health Insurance Benefits Assistance Program (SHIBA)

CALL 1-800-722-4134

TTY 1-800-735-2900

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

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

Pennsylvania

APPRISE

CALL 1-800-783-7067

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

WEBSITE www.aging.pa.gov

Puerto Rico

Office for the Elderly

CALL 1-787-721-6121

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

Rhode Island

Senior Health Insurance Program (SHIP)

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

TTY 1-401-462-0740

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

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

South Carolina

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

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

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

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

South Dakota

Senior Health Information & Insurance Education (SHIINE)

CALL 1-800-536-8197

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

WEBSITE www.shiine.net/

Tennessee

Tennessee State Health Insurance Assistance Program (SHIP)

CALL 1-877-801-0044

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

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

Texas

Texas Health Information Counseling & Advocacy Program (HICAP)

CALL 1-800-252-9240

TTY 711.0

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

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

Utah

State Health Insurance Assistance Program (SHIP)

CALL 1-800-541-7735

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

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

Vermont

Vermont State Health Insurance Assistance Program (SHIP)

CALL 1-800-642-5119

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

WEBSITE https://www.vermont4a.org/

Virginia

Virginia Insurance Counseling & Assistance Program (VICAP)

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

TTY 711.0

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

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

Washington

Statewide Health Insurance Benefits Advisors (SHIBA)

CALL 1-800-562-6900

TTY 1-360-586-0241

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

WEBSITE www.insurance.wa.gov/shiba

West Virginia

West Virginia SHIP

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

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

WEBSITE www.wvship.org/

Wisconsin

State Health Insurance Assistance Program (SHIP)

CALL 1-800-242-1060

TTY 1-262-347-3045

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

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

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)

CALL 1-800-856-4398

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

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

Appendix B: Quality Improvement Organizations (QIO) contact information

Alabama

KEPRO

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

Alaska

KEPRO

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

Arizona

Livanta

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

Arkansas

KEPRO

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

California

Livanta

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

Colorado

KEPRO

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

Connecticut

KEPRO

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

Delaware

Livanta

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

District of Columbia

Livanta

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

Florida

KEPRO

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

Georgia

KEPRO

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

Hawaii

Livanta

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

Idaho

KEPRO

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

Illinois

Livanta

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

Indiana

Livanta

CALL 1-888-524-9900

TTY 1-888-985-8775

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Iowa

Livanta

CALL 1-888-755-5580

TTY 1-888-985-9295

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Kansas

Livanta

CALL 1-888-755-5580

TTY 1-888-985-9295

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Kentucky

KEPRO

CALL 1-888-317-0751

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

WEBSITE www.keproqio.com

Louisiana

KEPRO

CALL 1-888-315-0636

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

WEBSITE www.keproqio.com

Maine

KEPRO

CALL 1-888-319-8452

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131

WEBSITE www.keproqio.com

Maryland

Livanta

CALL 1-888-396-4646

TTY 1-888-985-2660

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Massachusetts

KEPRO

CALL 1-888-319-8452

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131

WEBSITE www.keproqio.com

Michigan

Livanta

CALL 1-888-524-9900

TTY 1-888-985-8775

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Minnesota

Livanta

CALL 1-888-524-9900

TTY 1-888-985-8775

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Mississippi

KEPRO

CALL 1-888-317-0751

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

WEBSITE www.keproqio.com

Missouri

Livanta

CALL 1-888-755-5580

TTY 1-888-985-9295

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Montana

KEPRO

CALL 1-888-317-0891

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131

WEBSITE www.keproqio.com

Nebraska

Livanta

CALL 1-888-755-5580

TTY 1-888-985-9295

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

Nevada

Livanta

CALL 1-877-588-1123

TTY 1-855-887-6668

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., 24 hour voicemail service is available

WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701

WEBSITE www.livantaqio.com

New Hampshire

KEPRO

CALL 1-888-319-8452

TTY 1-855-843-4776

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m., Weekends and holidays, 11:00 a.m. – 3:00 p.m.

WRITE KEPRO, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131

WEBSITE www.keproqio.com

New Jersey

Livanta

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

New Mexico

KEPRO

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

New York

Livanta

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

North Carolina

KEPRO

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

North Dakota

KEPRO

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

Ohio

Livanta

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

Oklahoma

KEPRO

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

Oregon

KEPRO

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

Pennsylvania

Livanta

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

Rhode Island

KEPRO

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

South Carolina

KEPRO

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

South Dakota

KEPRO

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

Tennessee

KEPRO

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

Texas

KEPRO

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

Utah

KEPRO

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

Vermont

KEPRO

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

Virginia

Livanta

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

Washington

KEPRO

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

West Virginia

Livanta

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

Wisconsin

Livanta

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

Wyoming

KEPRO

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

Appendix C: State Medicaid Agencies contact information

Alabama

Alabama Medicaid Agency

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

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

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

WEBSITE www.medicaid.alabama.gov

Alaska

State of Alaska Department of Health & Social Services

CALL 1-800-770-5650, opción 2

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

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

WEBSITE http://dhss.alaska.gov

Arizona

Arizona Health Care Cost Containment System (AHCCCS)

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

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

WRITE Arizona Health Care Cost Containment System (AHCCCS), 801 E. Jefferson Street, Phoenix, AZ 85034

WEBSITE https://www.azahcccs.gov

Arkansas

Arkansas Medicaid

CALL 1-800-482-8988

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Arkansas Medicaid, Arkansas Division of Medical Services, Department of Human Services, Donaghey Plaza South, P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437

WEBSITE https://www.benefits.gov/benefit/1089

California

Medi-Cal

CALL 1-916 552-9200 or 1-800-541-5555

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

WRITE Medi-Cal, P.O. Box 997417, MS 4607, Sacramento, CA 95899-7417

WEBSITE www.dhcs.ca.gov

Colorado

Health First Colorado

CALL 1-303 866-2993 or 1-800-221-3943

TTY 711.0

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

WRITE Health First Colorado, Department of Health Care Policy & Financing, 1570 Grant Street, Denver, CO 80203

WEBSITE https://www.healthfirstcolorado.com/

Connecticut

Connecticut Department of Social Services

CALL 1-855-626-6632

TTY 1-800-842-4524

HOURS Monday – Friday, 7:30 a.m. – 4:00 p.m.

WRITE Connecticut Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033

WEBSITE www.ct.gov/dss

Delaware

Delaware Health & Social Services

CALL 1-302-255-9500 or 1-800-372-2022
HOURS Monday – Friday, 7:30 a.m. – 4:30 p.m.
WRITE Delaware Health & Social Services, Division of Medicaid and Medical Assistance, Lewis Building, Herman Holloway Sr. Campus, 1901 N. DuPont Highway, New Castle, DE 19720
WEBSITE www.dhss.delaware.gov/dhss/dmma/

District of Columbia

Department of Health Care Finance

CALL 1-202-442-5988
TTY 711.0
HOURS Monday – Friday, 8:15 a.m. – 4:45 p.m.
WRITE Department of Health Care Finance, 441 4th Street, NW, 900S, Washington, DC 20001
WEBSITE http://dhcf.dc.gov/

Florida

Agency For Health Care Administration

CALL 1-877-711-3662
TTY 1-866-467-4970
HOURS Monday – Thursday, 8:00 a.m. – 8:00 p.m., Friday, 8:00 a.m. – 7:00 p.m.
WRITE Agency For Health Care Administration, P.O. Box 5197, Tallahassee, FL 32314
WEBSITE http://www.flmedicaidmanagedcare.com/

Georgia

Georgia Department of Community Health

CALL 1-404-657-5468
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Georgia Department of Community Health, 2 Peachtree Street, NW, Atlanta, GA 30303
WEBSITE https://medicaid.georgia.gov

Hawaii

Department of Human Services

CALL 1-800-316-8005
TTY 1-800-603-1201
HOURS Monday – Friday, 7:45 a.m. – 4:30 p.m.
WRITE Department of Human Services, Med-QUEST Division, P.O. Box 700190, Kapolei, HI 96709-0190
WEBSITE http://humanservices.hawaii.gov/

Idaho

Idaho Department of Health and Welfare

CALL 1-877 456-1233 or 1-800-926-2588
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Idaho Department of Health and Welfare, 450 W State Street, Boise, ID 83702
WEBSITE http://www.healthandwelfare.idaho.gov/Medical/ Medicaid/tabid/123/Default.aspx

Illinois

Illinois Department of Healthcare and Family Services

CALL 1-800-843-6154
TTY 1-800-447-6404
HOURS Monday – Friday, 8:00 a.m. – 4:45 p.m.
WRITE Illinois Department of Healthcare and Family Services, 401 South Clinton, Chicago, IL 60607
WEBSITE www.illinois.gov/hfs/Pages/default.aspx

Indiana

Indiana Medicaid

CALL 1-317 713-9627 or 1-800-457-4584
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE Indiana Family & Social Services Administration, Division of Family Resources, Office of Medicaid Policy and Planning, 402 W. Washington Street, Room W382, Indianapolis, IN 46204-2739
WEBSITE http://www.in.gov/medicaid/members/

Iowa

Iowa Medicaid Enterprise

CALL 1-515-256-4606 or 1-800-338-8366
TTY 1-800-735-2942
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Iowa Medicaid Enterprise, Customer Service, P.O. Box 36510, Des Moines, IA 50315
WEBSITE http://dhs.iowa.gov/iahealthlink

Kansas

KanCare

CALL 1-800-792-4884
TTY 1-800-792-4292
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE KanCare, P.O. Box 3599, Topeka, KS 66601-9738
WEBSITE www.kancare.ks.gov/

Kentucky

Cabinet for Health and Family Services

CALL 1-855-306-8959
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Cabinet for Health and Family Services, Department for Medicaid Services, 275 East Main Street, Frankfort, KY 40621
WEBSITE https://chfs.ky.gov/agencies/dms/member/Pages/default.aspx

Louisiana

Louisiana Medicaid

CALL 1-888-342-6207
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Louisiana Medicaid, Department of Health and Hospitals, P.O. Box 629, Baton Rouge, LA 70821-0629
WEBSITE www.dhh.louisiana.gov

Maine

Office of MaineCare Services

CALL 1-855-797-4357
TTY 711.0
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Office of MaineCare Services, 11 State House Station, Augusta, ME 04333-0011
WEBSITE http://www.maine.gov/dhhs/oms/

Maryland

Maryland Department of Health & Mental Hygiene

CALL 1-410-767-6500 or 1-800-492-5231
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Medicaid/Medical Assistance, Maryland Department of Health & Mental Hygiene, 201 West Preston Street, Baltimore, MD 21201
WEBSITE https://health.maryland.gov/mmcp/pages/home.aspx

Massachusetts

Office of Medicaid

CALL 1-617-573-1770 or 1-800-841-2900
TTY 1-800-497-4648
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Office of Medicaid, One Ashburton Place, 11th Floor, Boston, MA 02108
WEBSITE www.mass.gov/masshealth

Michigan

Michigan Department of Health & Human Services

CALL 1-517-373-3740 or 1-800-642-3195
TTY 1-800-649-3777
HOURS Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE Michigan Department of Health & Human Services, 333 S. Grand Avenue, P.O. Box 30195, Lansing MI 48909
WEBSITE www.michigan.gov/mdhhs

Minnesota

Minnesota Department of Human Services

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

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Medical Assistance (MA), Minnesota Department of Human Services, P.O. Box 64989, St. Paul, MN 55164

WEBSITE http://mn.gov/dhs/

Mississippi

Mississippi Division of Medicaid

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

HOURS Monday – Friday, 7:30 a.m. – 5:00 p.m.

WRITE Mississippi Division of Medicaid, Sillers Building, 550 High Street, Suite 1000, Jackson, MS 39201-1399

WEBSITE www.medicaid.ms.gov

Missouri

MO HealthNet Division

CALL 1-573-751-3425 or 1-800-392-2161

TTY 1-800-735-2966

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

WRITE The State of Missouri, MO HealthNet Division, 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-6500

WEBSITE http://dss.mo.gov/mhd

Montana

Department of Public Health & Human Services

CALL 1-406-444-4455 or 1-800-362-8312

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

WRITE Department of Public Health & Human Services, Health Resources Division, P. O. Box 202951, Helena, MT 59620-2951

WEBSITE www.dphhs.mt.gov/

Nebraska

Nebraska Department of Health and Human Services

CALL 1-855-632-7633

TTY 1-402-471-7256

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

WRITE Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care, P.O. Box 95026, Lincoln, NE 68509-5026

WEBSITE http://dhhs.ne.gov

Nevada

Nevada Department of Health and Human Services

CALL 1-877-638-3472

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m.

WRITE Nevada Department of Health and Human Services, Division of Health Care Financing and Policy, 1100 E. William Street, Suite 111, Carson City, NV 89701

WEBSITE https://dwss.nv.gov/

New Hampshire

NH Department of Health and Human Services

CALL 1-603-271-4344 or 1-844-275-3447

TTY 1-800-735-2964

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Office of Medicaid Business & Policy, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301

WEBSITE https://www.dhhs.nh.gov/

New Jersey

NJ Department of Human Services

CALL 1-800-356-1561

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

WRITE NJ Department of Human Services, Division of Medical Assistance and Health Services, P.O. Box 712, Trenton, NJ 08625-0712

WEBSITE www.state.nj.us/humanservices/dmahs

New Mexico

NM Human Services Department's Medical Assistance Division

CALL	1-505-827-3100 or 1-888-997-2583
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	NM Human Services Department's Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504-2348
WEBSITE	https://nmmedicaid.portal.conduent.com/static/index.htm

New York

New York State Department of Health

CALL	1-800-541-2831
HOURS	Monday – Friday, 8:00 a.m. – 4:45 p.m.
WRITE	New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237
WEBSITE	www.health.ny.gov/health_care/medicaid/

North Carolina

NC Division of Medical Assistance

CALL	1-919-855-4100 or 1-800-662-7030
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	NC Division of Medical Assistance, 2501 Mail Service Center, Raleigh, NC 27699-2501
WEBSITE	https://medicaid.ncdhhs.gov/

North Dakota

North Dakota Department of Human Services

CALL	1-701-328-7068 or 1-800-755-2604
TTY	711.0
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	Medical Services Division, North Dakota Department of Human Services, 600 E. Boulevard Avenue, Dept 325, Bismarck, ND 58505-0250
WEBSITE	www.nd.gov/dhs/

Ohio

Ohio Department of Medicaid

CALL	1-800-324-8680
TTY	1-800-292-3572
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m., Saturday – Sunday, 8:00 a.m. – 5:00 p.m.
WRITE	Ohio Department of Medicaid, 50 West Town Street, Suite 400, Columbus, OH 43215
WEBSITE	http://medicaid.ohio.gov/

Oklahoma

Oklahoma Health Care Authority

CALL	1-405-522-7300 or 1-800-987-7767
TTY	711.0
HOURS	Monday – Friday, 8:00 a.m. – 5:30 p.m.
WRITE	Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105
WEBSITE	https://oklahoma.gov/ohca.html

Oregon

Oregon Health Plan

CALL	1-800-699-9075 or 1-800-273-0557
TTY	711.0
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	Oregon Health Plan, Health Systems Division, 500 Summer Street NE, Salem, OR 97301-1079
WEBSITE	www.oregon.gov/OHA/healthplan/

Pennsylvania

Pennsylvania Department of Human Services

CALL	1-800-692-7462
TTY	711.0
HOURS	Monday – Friday, 8:00 a.m. – 4:45 p.m.
WRITE	Pennsylvania Department of Human Services, Office of Medical Assistance Programs, P.O. Box 2675, Harrisburg, PA 17105-2675
WEBSITE	http://www.dhs.pa.gov/

Puerto Rico

Medicaid Program Dept of Health

CALL (787) 765-2929 Ext. 6700

WRITE Medicaid Program Department of Health, P.O. Box 70184 San Juan, PR 00936-8184

Rhode Island

Rhode Island Department of Human Services

CALL 1-855-697-4347

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:00 p.m.

WRITE Rhode Island Department of Human Services, Louis Pasteur Building, 600 New London Avenue, Cranston, RI 02921

WEBSITE www.dhs.ri.gov

South Carolina

South Carolina Health Connections Medicaid

CALL 1-888-549-0820

TTY 1-888-842-3620

HOURS Monday – Friday, 8:00 a.m. – 6:00 p.m., Saturday, 9:00 a.m. – 12:00 p.m.

WRITE Department of Health and Human Services, South Carolina Health Connections Medicaid, P.O. Box 8206, Columbia, SC 29202

WEBSITE www.scdhhs.gov

South Dakota

South Dakota Department of Social Services

CALL 1-605-773-4678 or 1-800-597-1603

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

WRITE South Dakota Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, SD 57501

WEBSITE http://dss.sd.gov/medicaid

Tennessee

TennCare

CALL 1-800-342-3145

TTY 1-877-779-3103

HOURS Monday – Friday, 7:00 a.m. – 6:00 p.m.

WRITE TennCare, 310 Great Circle Road, Nashville, TN 37243

WEBSITE www.tn.gov/tenncare/

Texas

Texas Health and Human Services Commission

CALL 1-512-424-6500 or 1-800-252-8263

TTY 1-800-735-2989

HOURS Monday – Friday, 7:30 a.m. – 5:30 p.m.

WRITE Texas Health and Human Services Commission, Brown-Heatly Building, 4900 N. Lamar Boulevard, Austin, TX 78751-2316

WEBSITE https://yourtexasbenefits.hhsc.texas.gov/

Utah

Utah Department of Health

CALL 1-801-538-6155 or 1-800-662-9651

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

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

WEBSITE https://medicaid.utah.gov/

Vermont

Green Mountain Care

CALL 1-800-250-8427

TTY 711.0

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

WRITE Green Mountain Care, Department of Vermont Health Access, 280 State Dr., Waterbury, VT 05671

WEBSITE www.greenmountaincare.org/

Virginia

Department of Medical Assistance Services

CALL 1-804-786-7933

TTY 1-800-343-0634

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

WRITE Department of Medical Assistance Services, Attn: Director's Office, 600 East Broad Street, Richmond, VA 23219

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

Washington

Washington Apple Health (Medicaid)

CALL 1-800-562-3022

TTY 711.0

HOURS Monday – Friday, 7:00 a.m. – 5:00 p.m.

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

WEBSITE http://www.hca.wa.gov/medicaid/Pages/index.aspx

West Virginia

West Virginia Bureau for Medical Services

CALL 1-304-558-1700 or 1-888-483-0797

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

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

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

Wisconsin

Department of Health Services

CALL 1-608-266-1865 or 1-800-362-3002

TTY 711.0

HOURS Monday – Friday, 7:45 a.m. – 4:30 p.m.

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

WEBSITE www.dhs.wisconsin.gov/

Wyoming

Wyoming Medicaid

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

TTY 1-307-777-5648

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

WRITE Wyoming Medicaid, 6101 Yellowstone Road, Suite 210, Cheyenne, WY 82009

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

Appendix D: State Pharmaceutical Assistance Programs (SPAP) contact information

Delaware

Chronic Renal Disease Program (CRDP)

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

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Chronic Renal Disease Program (CRDP), Delaware Health and Social Services (DHSS), 13 S.W. Front Street, Milford, DE 19963

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

Delaware

Delaware Prescription Assistance Program

CALL 1-800-996-9969

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

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

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

Indiana

HoosierRx

CALL 1-866-267-4679

HOURS Monday – Friday, 7:00 a.m. – 3:00 p.m.

WRITE HoosierRx, P.O. Box 6224, Indianapolis, IN 46206

WEBSITE https://www.in.gov/medicaid/members/194.htm

Maine

Maine DEL

CALL 1-866-796-2463

TTY 711.0

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Office for Family Independence, State of Maine-- DHHS, 114 Corn Shop Lane, Farmington, ME 04938-9900

WEBSITE https://www.mainecahc.org/guide-to-maine-health- care/other-helpful-programs/help-paying-for- prescriptions/#DEL

Massachusetts

Prescription Advantage

CALL 1-800-243-4636

TTY 1-877-610-0241

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

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

WEBSITE https://www.mass.gov/prescription-drug-assistance

Maryland

Maryland - SPDAP

CALL 1-800-551-5995

TTY 1-800-877-5156

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

WRITE Maryland - SPDAP, c/o Pool Administrators, 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033

WEBSITE http://marylandspdap.com

Maryland

Maryland Kidney Disease Program

CALL 1-410 767-5000 or 1-800-226-2142

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

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

WEBSITE www.mdrxprograms.com/kdp.html

Montana

Big Sky Rx Program

CALL 1-866-369-1233

TTY 711.0

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

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

WEBSITE https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky

Montana

Montana Mental Health Services Plan (MHSP)

CALL 1-406-443-7871

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

WRITE Montana Mental Health Services Plan (MHSP), 555 Fuller Ave., P.O. Box 202905, Helena, MT 59620-2905

WEBSITE Mental Health Services Plan (MHSP) Public Mental Health Services for Adults (mt.gov)

Nevada

Nevada Senior Rx

CALL 1-866-303-6323 (option 2)

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

WRITE Nevada Senior Rx, 1860 E. Sahara Avenue, Las Vegas, NV 89104

WEBSITE http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

New Jersey

Pharmaceutical Assistance to the Aged and Disabled (PAAD)

CALL 1-800-792-9745

HOURS 24 hours, 7 days a week automated system

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

WEBSITE http://www.state.nj.us/humanservices/doas/services/paad/

New York

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

CALL 1-800-332-3742

TTY 1-800-290-9138

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

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

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

Oklahoma

Rx for Oklahoma Prescription Assistance

CALL 1-877-794-6552

TTY 711.0

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

WRITE Rx for Oklahoma Prescription Assistance, Oklahoma Department of Commerce, 900 N. Stiles Ave., Oklahoma City, OK 73104

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

Pennsylvania

Pharmaceutical Assistance Contract for the Elderly (PACE)

CALL 1-717 651-3600 or 1-800-225-7223

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

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

WEBSITE http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Pennsylvania

PACE Needs Enhancement Tier (PACENET)

CALL 1-717 651-3600 or 1-800-225-7223

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

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

WEBSITE http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Pennsylvania

Special Pharmaceutical Benefits Program-Mental Health

CALL 1-800-433-4459

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Special Pharmaceutical Benefits Program-Mental Health, Department of Human Servcies OMHSAS, Commonwealth Tower 12th Floor, P.O. Box 2675, Harrisburg, PA 17105-2675

WEBSITE https://www.dhs.pa.gov/about/Pages/DHS-Sites.aspx

Pennsylvania

Chronic Renal Disease Program (CRDP)

CALL 1-800-225-7223

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

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

WEBSITE http://www.health.pa.gov/

Rhode Island

Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)

CALL 1-401-462-3000

TTY 1-401-462-0740

HOURS Monday – Friday, 8:30 a.m. – 4:00 p.m.

WRITE Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE), 57 Howard Avenue, Louis Pasteur Building, Cranston, RI 02920

WEBSITE http://oha.ri.gov/

Texas

Kidney Health Care Program

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

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

WRITE Kidney Health Care Program, Specialty Health Care Services, MC 1938, P.O. Box 149347, Austin, TX 78714

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

Vermont

Green Mountain Care, VPharm

CALL 1-800-250-8427

TTY 711.0

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

WRITE Green Mountain Care, VPharm, Health Access Customer Service, Department of Vermont Health Access, 312 Hurricane Lane, Williston, VT 05495

WEBSITE http://www.greenmountaincare.org/prescription

Wisconsin

SeniorCare

CALL 1-800-657-2038

HOURS Monday – Friday, 8:00 a.m. – 6:00 p.m.

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

WEBSITE www.dhs.wisconsin.gov/seniorcare/

Wisconsin

Wisconsin Chronic Renal Disease Program

CALL 1-800-362-3002

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

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

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

Wisconsin

Wisconsin Hemophilia Home Care Program

CALL	1-800-362-3002
HOURS	Monday – Friday, 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Hemophilia Home Care Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Adult Cystic Fibrosis Program

CALL	1-800-362-3002
HOURS	Monday – Friday, 8:30 a.m. – 4:30 p.m.
WRITE	Wisconsin Adult Cystic Fibrosis Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
WEBSITE	https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm

Appendix E: AIDS Drug Assistance Programs (ADAP) contact information

Alabama

Alabama AIDS Drug Assistance Program

CALL 1-866-574-9964

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

WRITE Alabama AIDS Drug Assistance Program, HIV/ AIDS Division, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104

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

Alaska

Alaskan AIDS Assistance Association

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

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

WRITE Alaskan AIDS Assistance Program, 1057 W. Fireweed Lane, Anchorage, AK 99503

WEBSITE http://www.alaskanaids.org/index.php/client-services/adap

Arizona

Arizona AIDS Drug Assistance Program

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

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

WRITE Arizona AIDS Drug Assistance Program, Arizona Department of Health, 150 North 18th Avenue, Suite 130, Phoenix, AZ 85007

WEBSITE http://www.azdhs.gov/phs/hiv/adap/

Arkansas

Arkansas AIDS Drug Assistance Program

CALL 1-501-661-2408 or 1-888-499-6544

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

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

WEBSITE http://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program

California

California AIDS Drug Assistance Program

CALL 1-844-421-7050

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

WRITE California AIDS Drug Assistance Program, CDPH, P.O. Box 997426, Mail Stop 7704, Sacramento, CA 95899

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

Colorado

Bridging the Gap, Colorado

CALL 1-303-692-2783

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

WRITE Bridging the Gap, Colorado-3835, 4300 Cherry Creek Dr. South, Denver, CO 80246-1530

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

Connecticut

Connecticut AIDS Drug Assistance Program

CALL 1-860-509-7806 or 1-800-233-2503

HOURS Monday – Friday, 7:30 a.m. – 4:00 p.m.

WRITE Connecticut AIDS Drug Assistance Program, Connecticut Department of Public Health, 410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134

WEBSITE http://www.ct.gov/dph/cwp/view.asp?a=3135&Q=387012

Delaware

Delaware AIDS Drug Assistance Program

CALL 1-302-744-1050

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

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

WEBSITE http://dhss.delaware.gov/dph/dpc/hivtreatment.html

District of Columbia

DC AIDS Drug Assistance Program

CALL 1-202-671-4900

TTY 711.0

HOURS Monday – Friday, 8:15 a.m. – 4:45 p.m.

WRITE DC AIDS Drug Assistance Program, District of Columbia Department of Health, 899 North Capitol Street NE, Washington, DC 20002

WEBSITE https://dchealth.dc.gov/DC-ADAP

Florida

Florida AIDS Drug Assistance Program

CALL 1-850-245-4422 or 1-800-352-2437

TTY 1-888-503-7118

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

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

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

Georgia

Georgia AIDS Assistance Program

CALL 1-404-463-0416

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m.

WRITE Georgia AIDS Assistance Program, Georgia Department of Public Health, 2 Peachtree Street NW, 15th Floor, Atlanta, GA 30303-3186

WEBSITE http://dph.georgia.gov/adap-program

Hawaii

Hawaii AIDS Drug Assistance Program

CALL 1-808-733-9360

HOURS Monday – Friday, 7:45 a.m. – 4:30 p.m.

WRITE Hawaii AIDS Drug Assistance Program, Hawaii Department of Health, Harm Reduction Services Branch, 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816

WEBSITE https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/

Idaho

Idaho AIDS Drug Assistance Program

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

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

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

WEBSITE http://www.healthandwelfare.idaho.gov/Health/ FamilyPlanning,STDHIV/HIVCareandTreatment/tabid/391/Default.aspx

Illinois

Illinois AIDS Drug Assistance Program

CALL 1-217-782-4977 or 1-800-825-3518

TTY 1-800-547-0466

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Illinois AIDS Drug Assistance Program, Illinois Department of Public Health, Illinois ADAP Office, 525 West Jefferson Street, Springfield, IL 62761

WEBSITE https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services

Indiana

Indiana AIDS Drug Assistance Program

CALL 1-866-588-4948

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

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

WEBSITE http://www.in.gov/isdh/17740.htm

Iowa

Iowa AIDS Drug Assistance Program

CALL 1-515 242-5150 or 1-866-227-9878

TTY 711 or 1-800-735-2942

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Iowa AIDS Drug Assistance Program, Iowa Department of Public Health, 321 E. 12th Street, Des Moines, IA 50319-0075

WEBSITE http://www.idph.iowa.gov/hivstdhep/hiv

Kansas

Kansas AIDS Drug Assistance Program

CALL 1-785-296-6174

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

WRITE Kansas AIDS Drug Assistance Program, Kansas Department of Health and Environment, 1000 SW Jackson, Suite 210, Topeka, KS 66612

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

Kentucky

Kentucky AIDS Drug Assistance Program

CALL 1-502-564-6539 or 1-800-420-7431

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Kentucky AIDS Drug Assistance Program, Kentucky Cabinet for Health and Family Services, Department for Public Health, HIV/AIDS Branch, 275 E. Main St. HS2E-C, Frankfort, KY 40621

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

Louisiana

Louisiana Drug Assistance Program (L-DAP)

CALL 1-504-568-7474

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

WRITE Louisiana Drug Assistance Program (L-DAP), Louisiana Health Access Program (LA HAP), 1450 Poydras St., Suite 2136, New Orleans, LA 70112

WEBSITE http://www.lahap.org/

Maine

Maine AIDS Drug Assistance Program

CALL 1-207-287-3747

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

WRITE Maine AIDS Drug Assistance Program, Division of Infectious Disease, Center for Disease Control and Prevention, Department of Health and Human Services, 286 Water Street, 11 State House Station, Augusta, ME 04333-0011

WEBSITE https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/index.shtml

Maryland

Maryland AIDS Drug Assistance Program

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

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE Maryland AIDS Drug Assistance Program, Maryland Department of Health & Mental Hygiene, Center for HIV Care Services, 201 West Preston Street, Baltimore, MD 21201

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

Massachusetts

Massachusetts HIV Drug Assistance Program (HDAP)

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

HOURS Monday – Friday, 9:00 a.m. – 5:00 p.m.

WRITE Massachusetts HIV Drug Assistance Program (HDAP), Community Research Initiative of New England, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129

WEBSITE http://crine.org/hdap/

Michigan

Michigan Drug Assistance Program

CALL 1-888-826-6565

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

WRITE Michigan Drug Assistance Program, HIV Care Section, Division of Health, Wellness and Disease Control, Michigan Department of Health and Human Services, 109 Michigan Avenue, 9th Floor, Lansing, MI 48913

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

Minnesota

Minnesota AIDS Drug Assistance Program

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

TTY 711.0

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE Minnesota AIDS Drug Assistance Program, Minnesota Department of Human Services, HIV/ AIDS Division, P.O. Box 64972, St. Paul, MN 55164-0972

WEBSITE http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

Mississippi

Mississippi AIDS Drug Assistance Program

CALL 1-601 576-7400 or 1-866-458-4948

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

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

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

Missouri

Missouri AIDS Drug Assistance Program

CALL 1-573-751-6113 or 1-866-628-9891

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

WRITE Missouri AIDS Drug Assistance Program, Missouri Department of Health & Senior Services, Bureau of HIV, STD, and Hepatitis, P.O. Box 570, Jefferson City, MO 65102-0570

WEBSITE http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

Montana

Montana AIDS Drug Assistance Program

CALL 1-406-444-4744

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

WRITE Montana AIDS Drug Assistance Program, Montana Department of Public Health and Human Services, HIV/STD Section, P.O. Box 202951, Cogswell Building C211, Helena, MT 59620-2951

WEBSITE https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog

Nebraska

Nebraska AIDS Drug Assistance Program

CALL 1-402-471-2101

HOURS Monday – Thursday, 8:00 a.m. – 5:00 p.m., Friday, 9:00 a.m. – 3:30 p.m.

WRITE Nebraska AIDS Drugs Assistance Program, Ryan White Program, P.O. Box 95206, Lincoln, NE 68509-5026

WEBSITE https://dhhs.ne.gov/Documents/RyanWhiteAIDSdrugAssistanceProgram.pdf

Nevada

Nevada AIDS Drug Assistance Program

CALL 1-775-684-4056

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

WRITE Nevada AIDS Drug Assistance Program, Nevada Division of Public and Behavioral Health, 4126 Technology Way, Suite 200, Carson City, NV 89706

WEBSITE http://dpbh.nv.gov/Programs/HIV-Ryan/ Ryan_White_Part_B_-_Home/

New Hampshire

New Hampshire AIDS Drug Assistance Program

CALL 1-603-271-9700 or 1-800-852-3345

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

WRITE New Hampshire AIDS Drug Assistance Program, New Hampshire Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301-3852

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

New Jersey

New Jersey AIDS Drug Distribution Program (ADDP)

CALL 1-877-613-4533 or 1-800-624-2377

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

WRITE New Jersey AIDS Drug Distribution Program (ADDP), New Jersey Department of Health, P.O. Box 360, Trenton, NJ 08625

WEBSITE http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml

New Mexico

New Mexico AIDS Drug Assistance Program

CALL 1-505-476-3628

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

WRITE New Mexico AIDS Drug Assistance Program, 1190 S. St. Francis Drive, Santa Fe, NM 87505

WEBSITE https://nmhealth.org/about/phd/idb/hats/

New York

New York AIDS Drug Assistance Program

CALL 1-518-459-1641 or 1-800-542-2437

TTY 1-518-459-0121

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

WRITE New York AIDS Drug Assistance Program, New York Department of Health, HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052

WEBSITE http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm

North Carolina

North Carolina HIV Medication Assistance Program (HMAP)

CALL 1-919 733-9161 or 1-877-466-2232

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

WRITE North Carolina HIV Medication Assistance Program (HMAP), NC Department of Health and Human Services, Communicable Disease Branch, Epidemiology Section, Division of Public Health, 1902 Mail Service Center, Raleigh, NC 27699-1902

WEBSITE http://epi.publichealth.nc.gov/cd/hiv/hmap.html

North Dakota

North Dakota Department of Health HIV/AIDS Program

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

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

WRITE North Dakota Department of Health, HIV/AIDS Program, 2635 East Main Ave., Bismarck, ND 58506-5520

WEBSITE https://www.ndhealth.gov/hiv/

Ohio

Ohio HIV Drug Assistance Program

CALL	1-800-777-4775
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	Ohio HIV Drug Assistance Program, Ohio Department of Health, HIV Care Services Section, 246 North High Street, Columbus, OH 43215
WEBSITE	https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/resources

Oklahoma

Oklahoma State Department of Health

CALL	1-405-271-4636 or 1-800-522-0203
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	Oklahoma State Department of Health, 1000 NE 10th, Room 614, Oklahoma City, OK 73117
WEBSITE	https://oklahoma.gov/health.html

Oregon

CAREAssist

CALL	1-971-673-0144 or 1-800-805-2313
TTY	711.0
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	CAREAssist, Oregon Health Authority, 800 NE Oregon Street, Suite 1105, Portland, OR 97232
WEBSITE	https://www.oregon.gov/oha/ph/diseasesconditions/hivstdviralhepatitis/hivcaretreatment/careassist/pages/index.aspx

Pennsylvania

Special Pharmaceutical Benefits Program

CALL	1-800-922-9384
HOURS	Monday – Friday, 8:00 a.m. – 4:30 p.m.
WRITE	Special Pharmaceutical Benefits Program, Pennsylvania Department of Health, 625 Forster St., H&W Bldg., Rm 611, Harrisburg, PA 17120
WEBSITE	https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx

Puerto Rico

MC-21

CALL	(787) 286-6032
HOURS	Monday – Friday, 8:00 a.m. – 5:00 p.m.
WRITE	MC-21, Road #1 Km. 33.3 Lot #4, Angora Industrial Park, Bo. Bairoa, Caguas, P.R. 00725

Rhode Island

Rhode Island AIDS Drug Assistance Program

CALL	1-401-462-3294
HOURS	Monday – Friday, 8:30 a.m. – 4:30 p.m.
WRITE	Rhode Island AIDS Drug Assistance Program, RI Department of Health, Office of HIV/AIDS & Viral Hepatitis, 3 Capitol Hill, Room 302, Providence, RI 02908
WEBSITE	http://www.health.ri.gov/diseases/hivaids/about/stayinghealthy/

South Carolina

South Carolina AIDS Drug Assistance Program

CALL 1-800-856-9954

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE South Carolina AIDS Drug Assistance Program, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201

WEBSITE http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/

South Dakota

Ryan White Part B CARE Program

CALL 1-605-773-3737 or 1-800-592-1861

HOURS Monday – Friday, 8:30 a.m. – 5:00 p.m.

WRITE Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th St., Pierre, SD 57501-1700

WEBSITE http://doh.sd.gov/diseases/infectious/ryanwhite/

Tennessee

Tennessee HIV Drug Assistance Program (HDAP)

CALL 1-615-532-2392

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

WRITE Tennessee HIV Drug Assistance Program (HDAP), Tennessee Department of Health, 710 James Robertson Parkway, Andrew Johnson Tower, Nashville, TN 37243

WEBSITE https://www.tn.gov/health/health-program-areas/std/std/ryanwhite.html

Texas

Texas HIV Medication Program

CALL 1-800-255-1090

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

WRITE Texas HIV Medication Program, MSJA, MC 1873, P.O. Box 149347, Austin, TX 78714-9347

WEBSITE http://www.dshs.texas.gov/hivstd/meds/

Utah

Utah AIDS Drug Assistance Program

CALL 1-801-538-6397

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

WRITE Utah AIDS Drug Assistance Program, Utah Department of Health, Bureau of Epidemiology, 288 North 1460 West, Box 142104, Salt Lake City, UT 84114-2104

WEBSITE https://ptc.health.utah.gov/treatment/ryan-white/

Vermont

Vermont Medication Assistance Program (VMAP)

CALL 1-802-951-4005

HOURS Monday – Friday, 8:00 a.m. – 4:30 p.m.

WRITE Vermont AIDS Drug Assistance Program, Vermont Department of Health, HIV/AIDS Program, 108 Cherry Street, Burlington, VT 05402

WEBSITE HIV Care | Vermont Department of Health (healthvermont.gov)

Virginia

Virginia Medication Assistance Program (VA MAP)

CALL 1-855-362-0658

TTY 711.0

HOURS Monday and Wednesday, 8:00 a.m. – 6:00 p.m., Tuesday, Thursday and Friday, 8:00 a.m. – 5:00 p.m.

WRITE Virginia Medication Assistance Program (VA MAP) Virginia Department of Health, Eligibility, 1st Floor, 109 Governor Street, Room 326, P.O. Box 2448, Richmond, VA 23218

WEBSITE https://www.vdh.virginia.gov/disease-prevention/eligibility/

Washington

Early Intervention Program (EIP)

CALL 1-360-236-3426 or 1-877-376-9316

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

WRITE Early Intervention Program (EIP), Washington State Department of Health, P.O. Box 47841, Olympia, WA 98504-7841

WEBSITE https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services

West Virginia

West Virginia AIDS Drug Assistance Program

CALL 1-304-558-2195 or 1-800-642-8244

HOURS Monday – Friday, 8:30 a.m. – 4:30 p.m.

WRITE West Virginia AIDS Drug Assistance Program, West Virginia Department of Health and Human Resources, 350 Capital Street, Room 125, Charleston, WV 25301

WEBSITE https://oeps.wv.gov/rwp/pages/default.aspx

Wisconsin

Wisconsin AIDS/HIV Drug Assistance Program

CALL 1-608-267-6875 or 1-800-991-5532

HOURS Monday – Friday, 7:00 a.m. – 4:30 p.m.

WRITE Wisconsin AIDS/HIV Drug Assistance Program, Wisconsin Department of Health Services, Attn: ADAP, P.O. Box 2659, Madison, WI 53701-2659

WEBSITE http://www.dhs.wisconsin.gov/aids-hiv/Resources/Overviews/AIDS_HIV_drug_reim.htm

Wyoming

Wyoming AIDS Drug Assistance Program

CALL 1-307-777-5856

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

WRITE Wyoming AIDS Drug Assistance Program, Wyoming Department of Health, 6101 Yellowstone Road, Suite 510, Cheyenne, WY 82002

WEBSITE https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/

Multi-language Interpreter Services

English – ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call **1-888-281-7867** (TTY 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-281-7867** (TTY 711).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-281-7867** (TTY 711)。

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-281-7867** TTY 711).

French Creole – ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-281-7867** (TTY 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-281-7867** (TTY 711)번으로 전화해 주십시오.

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-888-281-7867** (TTY 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-281-7867** (ATS 711).

Arabic – ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-281-7867** (711 TTY).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-281-7867** (телетайп 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-281-7867** (TTY 711).

Farsi/Persian – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-281-7867** (TTY: 711) تماس بگیرید.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-281-7867** (TTY 711).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-281-7867** (TTY 711).

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-281-7867** (TTY 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-281-7867** (TTY 711)まで、お電話にてご連絡ください。

Navajo – Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló̜, koji̜' hódíílnih **1-888-281-7867** (TTY 711).

Gujarati – ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-281-7867** (TTY 711).

Urdu توجہ دیں: اگرآپ اردو زبان بولتے ہیں تو آپ کےلئے زبان معاون خدمات مفت میں دستیاب ہیں۔ کال کریں **1-888-281-7867** (TTY 711)

Y0036_17_50169 ACCEPTED

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

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