



January 1 – December 31, 2020

EVIDENCE OF COVERAGE

Your Medicare Health Benefits and Services as a Member of Cigna-HealthSpring Advantage (HMO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2020. It explains how to get coverage for the health care services you need. **This is an important legal document.**

Please keep it in a safe place.

This plan, Cigna-HealthSpring Advantage (HMO), is offered by Cigna. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Cigna. When it says “plan” or “our plan,” it means Cigna-HealthSpring Advantage (HMO).)

This document is available for free in Spanish.

Please contact our Customer Service number at 1-800-668-3813 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.

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet). We can give you information in Braille, in large print, or other alternate formats if you need it.

Benefits and/or copayments/coinsurance may change on January 1, 2021.

The provider network may change at any time. You will receive notice when necessary.

2020 Evidence of Coverage
Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1.	Getting started as a member	3
	Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
Chapter 2.	Important phone numbers and resources	10
	Tells you how to get in touch with our plan (Cigna-HealthSpring Advantage (HMO)) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), and the Railroad Retirement Board.	
Chapter 3.	Using the plan’s coverage for your medical services	18
	Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan’s network and how to get care when you have an emergency.	
Chapter 4.	Medical Benefits Chart (what is covered and what you pay)	27
	Gives the details about which types of medical care are covered and <i>not</i> covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.	
Chapter 5.	Asking us to pay our share of a bill you have received for covered medical services	57
	Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services.	
Chapter 6.	Your rights and responsibilities	61
	Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
Chapter 7.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	69
	Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
	<ul style="list-style-type: none"> • Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care you think is covered by our plan. This includes asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon. • Explains how to make complaints about quality of care, waiting times, customer service, and other concerns. 	
Chapter 8.	Ending your membership in the plan	94
	Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
Chapter 9.	Legal notices	100
	Includes notices about governing law and about nondiscrimination.	
Chapter 10.	Definitions of important words	104
	Explains key terms used in this booklet.	

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1	Introduction.....	4
Section 1.1	You are enrolled in Cigna-HealthSpring Advantage (HMO), which is a Medicare HMO	4
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?.....	4
Section 1.3	Legal information about the <i>Evidence of Coverage</i>	4
SECTION 2	What makes you eligible to be a plan member?.....	4
Section 2.1	Your eligibility requirements.....	4
Section 2.2	What are Medicare Part A and Medicare Part B?	5
Section 2.3	Here is the plan service area for our plan	5
Section 2.4	U.S. Citizen or Lawful Presence.....	5
SECTION 3	What other materials will you get from us?.....	5
Section 3.1	Your plan membership card — Use it to get all covered care.....	5
Section 3.2	The <i>Provider and Pharmacy Directory</i> : Your guide to all providers in the plan's network.....	6
SECTION 4	Your monthly premium for your plan	6
Section 4.1	How much is your plan premium?	6
Section 4.2	Can we change your monthly plan premium during the year?	6
SECTION 5	Please keep your plan membership record up to date	6
Section 5.1	How to help make sure that we have accurate information about you.....	6
SECTION 6	We protect the privacy of your personal health information.....	7
Section 6.1	We make sure that your health information is protected.....	7
SECTION 7	How other insurance works with our plan.....	7
Section 7.1	Which plan pays first when you have other insurance?	7

SECTION 1 Introduction

Section 1.1 You are enrolled in Cigna-HealthSpring Advantage (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Cigna-HealthSpring Advantage (HMO).

There are different types of Medicare health plans. Cigna-HealthSpring Advantage (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Cigna-HealthSpring Advantage (HMO) does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: <https://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* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Cigna-HealthSpring Advantage (HMO).

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.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage***It's part of our contract with you**

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form and 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, 2020 and December 31, 2020.

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, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue 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 (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- — *and* — You live in our geographic service area (Section 2.3 below describes our service area)
- — *and* — You are a United States citizen or are lawfully present in the United States
- — *and* — You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different Medicare Advantage plan that was terminated

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician’s services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, 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.

Our service area includes these counties in Pennsylvania: Bucks, Chester, Delaware, Lancaster, Montgomery, Philadelphia

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). 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.

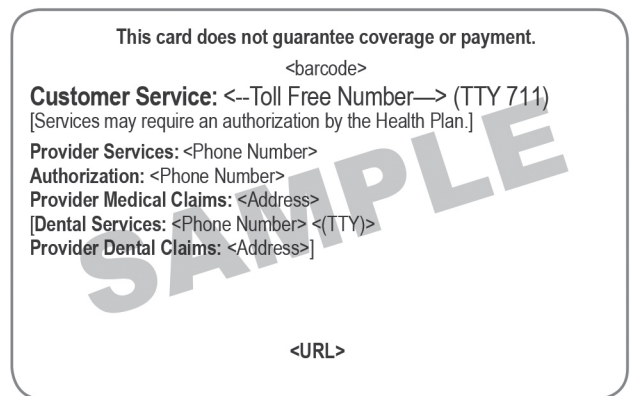
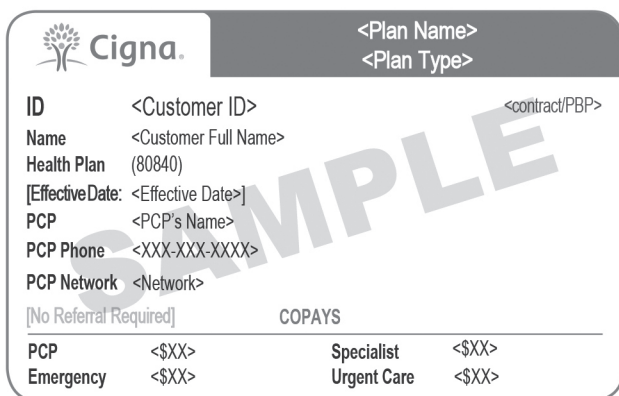
Section 2.4 U.S. Citizen or Lawful Presence

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-HealthSpring Advantage (HMO) if you are not eligible to remain a member on this basis. Cigna-HealthSpring Advantage (HMO) must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card — Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan 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:



As long as you are a member of our plan, in most cases, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your Medicare card if you need hospital services. Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here’s why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Cigna-HealthSpring Advantage (HMO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The 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.

What are “network providers”?

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. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.cignamedicare.com.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. When you select a Primary Care Physician (PCP), you are also selecting an entire network (a specific group of Plan providers) of specialists and hospitals. Please call Customer Service for details regarding the specialists and hospitals you may use. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider and Pharmacy Directory* at www.cignamedicare.com, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for your plan**Section 4.1 How much is your plan premium?**

You do not pay a separate monthly plan premium for your plan. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2020* gives information about these premiums in the section called “2020 Medicare Costs.” This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2020* from the Medicare website (<https://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 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date**Section 5.1 How to help make sure that we have accurate information about you**

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your Primary Care Provider/Medical Group/IPA. A Medical Group is an association of primary care providers (PCPs), specialists and/or ancillary providers, such as therapists and radiologists. An Independent Physician Association, or IPA, is a group of primary care and specialty care physicians who work together in coordinating your medical needs.

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

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.

Read over the information we send you about any other insurance coverage you have

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. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once a year, and also when Medicare informs us of changes in your other insurance coverage, we will send you a letter along with a questionnaire to confirm the other insurance coverage. Please complete the questionnaire and return it to us or call Customer Service to let us know if you still have the other insurance coverage or it has ended. If you have other medical insurance coverage or drug insurance coverage that is not listed on the letter, please call Customer Service to let us know about this other coverage (the Customer Service phone number is printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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.

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):

Chapter 1. Getting started as a member

- If you're under 65 and disabled and you or your family member are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
- If you're over 65 and you or your spouse are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). 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.

CHAPTER 2

*Important phone numbers
and resources*

Chapter 2. Important phone numbers and resources

SECTION 1	Plan contacts (how to contact us, including how to reach Customer Service at the plan).....	11
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program).....	13
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....	14
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)	14
SECTION 5	Social Security	15
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)	15
SECTION 7	How to contact the Railroad Retirement Board	16
SECTION 8	Do you have “group insurance” or other health insurance from an employer?	16

SECTION 1 Plan contacts

(how to contact us, including how to reach Customer Service at the plan)

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	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-888-766-6403
WRITE	Cigna, Attn: Member Services, 2800 North Loop West, Houston, TX 77092 LetUsHelpYou@healthspring.com
WEBSITE	www.cignamedicare.com

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

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

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-888-766-6403
WRITE	Cigna, Attn: Precertification Department, P.O. Box 20002, Nashville, TN 37202

How to contact us when you are making 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 7 (*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. 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	1-800-931-0149
WRITE	Cigna, Attn: Part C Appeals, P.O. Box 24087, Nashville, TN 37202-4087

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

Method	Complaints about Medical Care – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
WRITE	Cigna, Attn: Member Grievances, P.O. Box 2888, Houston, TX 77252
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

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

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 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

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

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

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	https://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 booklets 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: <ul style="list-style-type: none"> • 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 <i>estimate</i> 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: <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://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, print it out, and send it to 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. In Pennsylvania, the SHIP is called APPRISE.

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

APPRISE counselors can help you with your Medicare questions or problems. They 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. APPRISE counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	APPRISE (Pennsylvania's SHIP) – Contact Information
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

SECTION 4 Quality Improvement Organization
 (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Pennsylvania, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are 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. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta 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.

Method	Livanta (Pennsylvania's Quality Improvement Organization) – Contact Information
CALL	1-888-396-4646 Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
TTY	1-888-985-2660 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

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. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 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 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid

(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **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+).)
- **Qualified 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, contact Pennsylvania Department of Human Services.

Method	Pennsylvania Department of Human Services – Contact Information
CALL	1-800-692-7462 Hours are Mon. – Fri. 8:30 a.m. – 4:45 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
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/

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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.

Method	Railroad Retirement Board – Contact Information
CALL	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>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.</p> <p>If you press “1,” you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.</p>
TTY	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
WEBSITE	https://secure.rrb.gov/

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

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

CHAPTER 3

*Using the plan's coverage
for your medical services*

Chapter 3. Using the plan’s coverage for your medical services

SECTION 1	Things to know about getting your medical care covered as a member of our plan.....	19
Section 1.1	What are “network providers” and “covered services”?.....	19
Section 1.2	Basic rules for getting your medical care covered by the plan	19
SECTION 2	Use providers in the plan’s network to get your medical care	19
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care	19
Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?	20
Section 2.3	How to get care from specialists and other network providers	20
Section 2.4	How to get care from out-of-network providers	21
SECTION 3	How to get covered services when you have an emergency or urgent need for care or during a disaster	21
Section 3.1	Getting care if you have a medical emergency	21
Section 3.2	Getting care when you have an urgent need for services	22
Section 3.3	Getting care during a disaster	22
SECTION 4	What if you are billed directly for the full cost of your covered services?.....	22
Section 4.1	You can ask us to pay our share of the cost of covered services.....	22
Section 4.2	If services are not covered by our plan, you must pay the full cost	23
SECTION 5	How are your medical services covered when you are in a “clinical research study”?	23
Section 5.1	What is a “clinical research study”?.....	23
Section 5.2	When you participate in a clinical research study, who pays for what?	23
SECTION 6	Rules for getting care covered in a “religious non-medical health care institution”.....	24
Section 6.1	What is a religious non-medical health care institution?	24
Section 6.2	What care from a religious non-medical health care institution is covered by our plan?	24
SECTION 7	Rules for ownership of durable medical equipment	25
Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?.....	25