

Evidence of coverage

January 1 – December 31, 2025

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Cigna Healthcare Preferred Medicare (HMO)

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 to December 31, 2025. **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, seven days a week, 8 a.m. – 8 p.m. local time.

April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).

This plan, Cigna Healthcare® Preferred Medicare (HMO), 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 Healthcare Preferred Medicare [HMO].)

This document is available for free in Spanish.

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

Benefits and/or copayments/coinsurance may change on January 1, 2026.

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 benefits;
- 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.



2025 Evidence of Coverage Table of Contents

CHAPTER 1: Getting started as a member	5
SECTION 1 Introduction	6
SECTION 2 What makes you eligible to be a plan member?	6
SECTION 3 Important membership materials you will receive	7
SECTION 4 Your monthly costs for your plan	8
SECTION 5 More information about your monthly premium	10
SECTION 6 Keeping your plan membership record up to date	11
SECTION 7 How other insurance works with our plan	11
CHAPTER 2: Important phone numbers and resources	13
SECTION 1 Cigna Healthcare Preferred Medicare (HMO) contacts (how to contact us, including how to reach Customer Service at the plan)	14
SECTION 2 Medicare (how to get help and information directly from the federal Medicare program)	16
SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)	17
SECTION 4 Quality Improvement Organization	18
SECTION 5 Social Security	18
SECTION 6 Medicaid	18
SECTION 7 Information about programs to help people pay for their prescription drugs	19
SECTION 8 How to contact the Railroad Retirement Board	21
SECTION 9 Do you have “group insurance” or other health insurance from an employer?	21
CHAPTER 3: Using the plan for your medical services	22
SECTION 1 Things to know about getting your medical care as a member of our plan	23
SECTION 2 Use providers in the plan’s network to get your medical care	24
SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster	26
SECTION 4 What if you are billed directly for the full cost of your services?	27
SECTION 5 How are your medical services covered when you are in a “clinical research study”?	27
SECTION 6 Rules for getting care in a “religious non-medical health care institution”	29
SECTION 7 Rules for ownership of durable medical equipment	29
CHAPTER 4: Medical Benefits Chart (what is covered and what you pay)	31
SECTION 1 Understanding your out-of-pocket costs for covered services	32
SECTION 2 Use the Medical Benefits Chart to find out what is covered and how much you will pay	33
SECTION 3 What services are not covered by the plan?	34

CHAPTER 5: Using the plan's coverage for Part D prescription drugs.....	35
SECTION 1 Introduction	36
SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service	36
SECTION 3 Your drugs need to be on the plan's "Drug List"	38
SECTION 4 There are restrictions on coverage for some drugs	40
SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?	40
SECTION 6 What if your coverage changes for one of your drugs?	42
SECTION 7 What types of drugs are not covered by the plan?	44
SECTION 8 Filling a prescription	44
SECTION 9 Part D drug coverage in special situations	45
SECTION 10 Programs on drug safety and managing medications	46
CHAPTER 6: What you pay for your Part D prescription drugs.....	48
SECTION 1 Introduction	49
SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug	50
SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in	51
SECTION 4 Deductible information	52
SECTION 5 During the Initial Coverage Stage, the plan pays share of your drug costs and you pay your share	52
SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs	53
SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them	53
CHAPTER 7: Asking us to pay our share of a bill you have received for covered medical services or drugs	55
SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs	56
SECTION 2 How to ask us to pay you back or to pay a bill you have received	57
SECTION 3 We will consider your request for payment and say yes or no	57
CHAPTER 8: Your rights and responsibilities	59
SECTION 1 Our plan must honor your rights as a member of the plan	60
SECTION 2 You have some responsibilities as a member of the plan	64
CHAPTER 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	66
SECTION 1 Introduction	67
SECTION 2 Where to get more information and personalized assistance	67
SECTION 3 To deal with your problem, which process should you use?	67
SECTION 4 A guide to the basics of coverage decisions and appeals	68
SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision	70
SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal	74

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon 84

SECTION 9 Taking your appeal to Level 3 and beyond..... 86

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns..... 88

CHAPTER 10: Ending your membership in the plan 90

SECTION 1 Introduction to ending your membership in our plan..... 91

SECTION 2 When can you end your membership in our plan? 91

SECTION 3 How do you end your membership in our plan?..... 93

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan 93

SECTION 5 Cigna Healthcare must end your membership in the plan in certain situations 93

CHAPTER 11: Legal notices 95

SECTION 1 Notice about governing law 96

SECTION 2 Notice about non-discrimination..... 96

SECTION 3 Notice about Medicare Secondary Payer subrogation rights 96

CHAPTER 12: Definitions of important words 97

APPENDIX.....104

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Cigna Healthcare Preferred Medicare (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Cigna Healthcare Preferred Medicare (HMO). 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 Healthcare Preferred Medicare (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) 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's) 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 and prescription drugs. 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 words “coverage” and “covered services” refer to the medical care and services and the prescription drugs available to you as a member of Cigna Healthcare Preferred Medicare (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* document.

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* and *Evidence of Coverage Snapshot* are part of our contract with you about how Cigna Healthcare Preferred Medicare (HMO) covers your care. Other parts of this contract include the *List of Covered Drugs (Formulary)* 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 the months in which you are enrolled in Cigna Healthcare Preferred Medicare (HMO) between January 1, 2025, and December 31, 2025.

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 Cigna Healthcare Preferred Medicare (HMO) after December 31, 2025. We can also choose to stop offering the plan in your service area after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Cigna Healthcare Preferred Medicare (HMO) 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)
- — 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 Cigna Healthcare Preferred Medicare (HMO)

Cigna Healthcare Preferred Medicare (HMO) 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 in your *Evidence of Coverage Snapshot* and Benefit Summary.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact your Plan Sponsor 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 our plan if you are not eligible to remain a member on this basis. Cigna Healthcare must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. 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:

Cigna Preferred Medicare (HMO) ABC Company			
Name	Jane Doe	ID	H4513-8##
ID	12345678	Health Plan	(80840)
Effective Date	01/01/2025	MedicareRx	Prescription Drug Coverage
[No Referral Required]		COPAYS	
PCP	\$10	Specialist	\$20
Emergency	\$90	Urgent Care	\$35

This card does not guarantee coverage or payment.

Services may require a referral or an authorization by the Health Plan.

Customer Service 1-888-281-7867 (TTY 711)

Provider Services 1-800-230-6138

Authorization 1-800-453-4464

Provider Medical Claims Cigna PO Box 981706 El Paso, TX 79998
1-800-922-1557

Pharmacy Help Desk 1-800-922-1557

Pharmacy Claims Cigna Healthcare Attn: Medicare Part D
PO Box 14718 Lexington, KY 40512-4718
myCigna.com

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 Healthcare Preferred Medicare (HMO) 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, require hospice services, or participate in Medicare-approved clinical research 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. Phone numbers for Customer Service are listed on the back cover of this booklet.

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.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at Cignamedicare.com/group/maresources. Or you can request a copy from Customer Service.

Section 3.3 Provider and Pharmacy Directory: Your guide to pharmacies in our network

The *Provider and Pharmacy Directory* lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the Pharmacy Directory to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

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

Section 3.4 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 our plan. 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 plan Drug List.

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

The Drug List 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, 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)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium. 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 2025* handbook, specifically the section called 2025 Medicare Costs. If you need a copy, you can download it from the Medicare website www.medicare.gov/medicare-and-you. 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.

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.

When you first enroll in our plan, we let you know the amount of the penalty.

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 Veterans Health Administration (VA). 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.
 - 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.
 - 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 2025, this average premium amount is \$32.74.
- 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 two 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 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a Part D late enrollment penalty, contact your Plan Administrator

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.

If your modified adjusted gross income as reported on your IRS tax return from two 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.

- If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.
- 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.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit <https://www.medicare.gov> on the Web or call 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 may call Social Security at 1-800-772-1213 TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2025* gives information about the Medicare premiums in the section called "2025 Medicare Costs."

This explains how the Medicare Part B and Part D premiums differ 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 2025* 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 should call 1-877-486-2018.

Your coverage is provided through a contract with your current or former employer or union. Please contact your plan sponsor for information about your plan premium. If you are having trouble paying your plan premium on time, please contact Customer Service to see if we can direct you to programs that will help with your premium. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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 notify 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.

However, in some cases, you may need to start paying or may be able to stop paying a late enrollment penalty, if owed. This could happen if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for “Extra Help” during the year, you would be able to stop paying your penalty.
- If you lose “Extra Help,” you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

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

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, pharmacists, 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 and drugs 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 (Note: You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

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

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or end-stage renal disease (ESRD):
 - If you’re under 65 and disabled and you or your family member is 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 is 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 Cigna Healthcare Preferred Medicare (HMO) 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	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i> Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
WRITE	Cigna Healthcare Medicare Services, Attn: Medicare Customer Service, P.O. Box 1004, Nashville, TN 37202
VISIT	Cigna Healthcaremedicare.com/group/maresources

How to contact us when you are asking for a coverage decision or appeal about your medical care or 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 medical services or 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 asking for coverage decisions or appeals about your medical care or 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 Medical Care – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Hours are October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
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 October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
FAX	1-866-730-1896
WRITE	Cigna Healthcare Medicare Services, Attn: Prior Authorization Dept., P.O. Box 29030, Phoenix, AZ 85038

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Hours are October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
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 October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
FAX	1-866-845-7267
WRITE	Cigna Healthcare, Attn: Medicare Reviews P.O. Box 66571, St. Louis, MO 63166-6571
VISIT	Cigna Healthcaremedicare.com/group/maresources

Method	Appeals for Medical Care or 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 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday 8 a.m. – 8 p.m. local time. <i>Messaging service used weekends, after hours, and on federal holidays.</i>
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. April 1 – September 30, Monday – Friday 8 a.m. – 8 p.m. local time. <i>Messaging service used weekends, after hours, and on federal holidays.</i>
FAX	1-855-350-8671 (Medical Appeals)
WRITE	Appeals for Medical Care: Cigna Healthcare, Attn: Part C Appeals Unit, P.O. Box 188081, Chattanooga, TN 37422 Appeals for Part D Prescription Drugs: Cigna Healthcare Medicare Services, Attn: Cigna Healthcare Medicare Claims, P.O. Box 38639, Phoenix, AZ 85063-8639
VISIT	Cigna Healthcaremedicare.com/group/maresources

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

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 or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*).

Method	Complaints about Medical Care or Part D Prescription Drugs – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Hours are October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>

Method	Complaints about Medical Care or Part D Prescription Drugs – Contact Information
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 October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
FAX	1-866-567-2474
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 .

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

If you have received a bill (such as a provider bill) or paid for services that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. 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.

Method	Payment Requests – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Hours are October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
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 October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. <i>Messaging service used on weekends, after hours, and on federal holidays.</i>
WRITE	Part C (Medical Services): Cigna Healthcare, Direct Member Reimbursement, Medical Claims, P.O. Box 1004, Nashville, TN 37202 Part D (Prescription Drugs): Cigna Healthcare, Attn: Medicare Part D, P.O. Box 14718, Lexington, KY 40512-4718
VISIT	CignaHealthcaremedicare.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 (ESRD; 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

Method	Medicare – Contact Information
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.
VISIT	www.medicare.gov
Method	<p>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.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <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 estimate of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <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 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. <p>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.)</p>

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. See Appendix A of this booklet for a list of the State Health Insurance Assistance Programs.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. See Appendix B of this booklet for a list of Quality Improvement Organizations (QIOs).

QIOs have 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. QIOs are independent organizations. They are 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 a.m. to 7 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.
Method	Social Security – Contact Information
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 a.m. to 7 p.m., Monday through Friday.
WRITE	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” include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits [QMB+].)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits [SLMB+].)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid Agency for your state listed in Appendix C of this booklet.

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

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.

If you automatically qualify for "Extra Help," Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify, 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 the following:

- Medicare at 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 8 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications).
- Your State Medicaid Office (applications; see Section 6 of this Chapter 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 a process for 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 send proof of your Medicaid status to:

Cigna Healthcare Medicare Services
Attn: Medicare Customer Service
P.O. Box 29030
Phoenix, AZ 85038

- 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
 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 who is living in a facility, 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
- For individuals receiving home and community based services (HCBS), you may submit a copy of one of the following:
 1. 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
 2. 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
 3. 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
 4. Other documentation provided by the state showing HCBS eligibility status during a month after June of the previous calendar year
 5. A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS
- 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 (phone numbers are printed on the back cover of this booklet) if you have questions.

What if you have “Extra Help” and coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

What if you have “Extra Help” and 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 on the ADAP formulary qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program. 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 change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please see information on ADAP in Appendix D.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. “Extra Help” from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than

participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time; April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call on weekends, holidays and after hours. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Customer Service is available October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time; April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call on weekends, holidays and after hours.
WRITE	Express Scripts Medicare Prescription Payment Plan PO Box 2 Saint Louis, MO 63166 This address is only to be used for general inquiries. Additional addresses will be provided for the paper election forms and for the payment process.
VISIT	express-scripts.com/mppp

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 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to Noon on Wednesday. If you press “1,” you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
WRITE	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 <i>not</i> free.
VISIT	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 Customer Service 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 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 *Evidence of Coverage Snapshot* you were mailed.

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, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the *Evidence of Coverage Snapshot*. Your covered services for prescription drugs are discussed in Chapter 5 and 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.** (This chart is found in the *Evidence of Coverage Snapshot* we mailed you.)
- **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 have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
- **You receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this and to see what “emergency or urgently needed services” means, see Section 2 in this chapter.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network who provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network. Authorization must be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay the plan for dialysis can never exceed the cost-sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network, the cost-sharing for the dialysis may be higher.

SECTION 2 Use providers in the plan's network to get your medical care

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

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

When you become a member of our plan, you must choose a plan provider to be your Primary Care Provider (PCP). Your PCP is a doctor whose specialty is Family Medicine, Internal Medicine, General Practice, Geriatrics, or Pediatrics who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our plan. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care.

Coordinating your services includes checking or consulting with other plan providers about your care and how it is going.

In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

You select a PCP from your Provider and Pharmacy Directory and call Customer Service with your selection. The directory is continually being updated; therefore, please contact Customer Service to be sure the provider is accepting new patients. Customer Service is available to assist with your selection and to help find a doctor to meet your needs. Customer Service can also help you check to see if a provider is in our network of providers. The name and office telephone number of your PCP is printed on your membership card.

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. Please see Section 2.3 in this chapter for additional details.

Your change will take place the first of the following month. To change your PCP, please call Customer Service. Customer Service will confirm that the PCP you want to switch to is accepting new patients. We will change your membership record to the new PCP and confirm when the change to your new PCP will take effect. You will receive a new membership card that shows the name and phone number of your new PCP.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services, which are services requiring immediate medical attention that are not

emergencies, provided you are temporarily outside the service area of the plan or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual check-ups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

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

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

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

You must choose a Primary Care Provider (PCP) from the designated Cigna Healthcare network. Your PCP will help direct you to any additional specialists or services you may need.

You may generally change your PCP at any time if you want to see a plan specialist to whom your current PCP does not refer. Chapter 4, Section 2.1 contains more information about which services require prior authorization.

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

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. Authorization rules may apply.
- 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 care complaint to the QIO, a quality care of grievance to the plan, or both. Please see Chapter 9.

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

If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Please note that you must first obtain authorization from our plan before obtaining services from out-of-network providers. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 3.2 in this chapter. Members are entitled to receive services from out-of-network providers for emergency or out-of-area urgently needed services. Dialysis services are covered for ESRD members who have travelled outside of the plan's service area and are not able to access contracted ESRD providers.

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, an 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 us at the Customer Service number on the back 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. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- — or — The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual check-ups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

For a list of urgent care centers in our network, please refer to our *Provider and Pharmacy Directory*. The most recent list is available on our website at Cignamedicare.com/group/mareources. You can call Customer Service (the phone number is printed on the back cover of this document) for information on how to access urgent care centers.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances described in the Emergency Care and Urgently Needed Services benefits listed in the *Evidence of Coverage Snapshot*.

Section 3.3 Getting care during a disaster

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

Please visit: www.Cigna.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. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

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

If you have paid more than your plan cost-sharing for covered services or if you have received a bill for the full cost of covered medical services, go to Chapter 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 full 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 to 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 requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies 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, 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.
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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

SECTION 6 Rules for getting care in a “religious non-medical health care institution”**Section 6.1 What is a religious non-medical health care institution?**

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

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

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment**Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?**

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

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

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then you joined our plan. The payments you made in Original Medicare do not count.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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

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

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

What happens if you leave 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. For 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.

- **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.)
- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. Refer to the *Evidence of Coverage Snapshot* for further details regarding the deductible.
- **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?

Refer to your *Evidence of Coverage Snapshot* to learn 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 not 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.
- 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
- If you believe a provider has “balance billed” you, call Customer Service.

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

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

The Medical Benefits Chart in the *Evidence of Coverage Snapshot* lists the services our plan covers and what you pay out-of-pocket for each service and Part D prescription. The services listed in the *Evidence of Coverage Snapshot* 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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in bold print.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.
- We may also charge you administrative fees for missed appointments or for not paying your required cost-sharing at the time of service. Call Customer Service if you have questions regarding these administrative fees.

Other important things to know about our coverage:

- 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 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, 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, are not covered by this plan. Refer to the *Evidence of Coverage Snapshot* for a chart that lists services and items that either are not covered under any condition or are covered only under specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

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 4 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, a 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 home delivery 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.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service

Section 2.1 To have your prescription covered, 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. Contact us to find out about how your out-of-pocket costs could vary for different drugs.

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 home delivery service

For certain kinds of drugs, you can use the plan's network home delivery 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 home delivery service allows you to order a **30-day, 60-day, or 90-day supply**.

You may go to any of our network home delivery pharmacies. *The Provider and Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost-sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us.

To get information about filling your prescriptions by mail, please visit our website (Cignamedicare.com/group/maresources) or contact Customer Service (phone numbers are on the back cover of this booklet).

Usually a home delivery pharmacy order will get to you in no more than 14 days. In the event a mail order package is delayed, the home delivery 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 logging in to www.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 logging in to www.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.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling 1-877-860-0982 (TTY 711) or logging in to www.mycigna.com.

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 are in need of 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 home delivery 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 logging in to www.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. 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 home delivery program. Please see Section 2.3 for more information.

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. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. 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 in-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 you 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.

Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical conditions that they cover.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer.

Biological products are drugs that are more complex than typical drugs. 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. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drugs or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 12 for definitions of the types of drugs that may be on the Drug List.

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 four “cost-sharing tiers” for drugs on the Drug List

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

- Tier 1 drugs are Generic drugs. This is our lowest cost-sharing tier.
- Tier 2 drugs are Preferred Brand Drugs.
- Tier 3 drugs are Non-Preferred Drugs.
- Tier 4 drugs are Specialty Drugs.

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. Check the most recent Drug List we provided electronically. (Please note: 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.)
2. Visit the plan's website (Cignamedicare.com/group/maresources). The Drug List on the website is always the most current.
3. 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 help our members 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).

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 Customer Service 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 needs 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. Or 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.
- Your drug is not on the Drug List or your drug is restricted. (Go to Section 5.2 to learn what you can do.)
- Your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be. (Go to Section 5.3 to learn what you can do.)

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 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 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 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.

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

1) You can change to another drug.

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.

2) 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 it.

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 4 (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.
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change the plan's Drug List. See Chapter 12 for definitions of the drug types discussed in this chapter.

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

- Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.
 - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - We will make these immediate changes only if we are adding a new generic version of a brand name or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.
 - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We will tell you at least 30 days before we make the change, or we will tell you about the change and cover a 30-day fill of the version of the drug you are taking.
- Removing 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 after we make the change.
- Making 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, changes may be made based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - We will tell you at least 30 days before we make these changes, or we will tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 9.

Changes to drugs on the Drug List 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 four 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, these categories of drugs are not covered by Medicare drug plans. (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)

- 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

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. We offer coverage for select erectile dysfunction drugs with quantity limitations. Additional details are available in the plan's comprehensive drug list. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)

SECTION 8 Filling 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, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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 a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care 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 or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree 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, at least 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 their prescription opioid medications 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 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 them 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 that has a recommended to-do list and 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, you 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 from the program. If you have any questions about this program, please contact Customer Service.

CHAPTER 6:

What you pay for your Part D prescription drugs

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 Introduction

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

This chapter focuses on what you pay for your 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. When you use the plan’s “Real-Time Benefit Tool” to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in “real time,” meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the “Real-Time Benefit Tool” by calling Customer Service.

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.

- **Deductible** is the amount you must 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 are included in your out-of-pocket costs

Your out-of-pocket-costs include 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 applicable
 - The Initial Coverage 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, by a State Pharmaceutical Assistance Program that is qualified by Medicare, by employer or union health plans, or by the Indian Health Service. Payments made by Medicare’s “Extra Help” Program are also included.

Moving on to the Catastrophic Coverage Stage

When you (or those paying on your behalf) have spent a total of \$2,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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:

- Your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug plan
- Payments for your drugs that are made by the Veterans Health Administration (VA)
- Payments for your drugs that are made by TRICARE
- 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 that are made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

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 \$2,000, this report will tell you that you have left the Initial Coverage 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 three “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 as follows.

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: 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. This is called your **out-of-pocket costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by “Extra Help” from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **“total drug costs.”**

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D Explanation of 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 when 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 these 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 and help qualify you for catastrophic coverage. 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 the 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

Refer to your *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 share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four cost-sharing tiers

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

- Tier 1 drugs are Generic drugs. This is our lowest cost-sharing tier.
- Tier 2 drugs are Preferred Brand Drugs.
- Tier 3 drugs are Non-Preferred Drugs.
- Tier 4 drugs are Specialty Drugs.

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 home delivery 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

Please refer to the *Evidence of Coverage Snapshot* for a table that 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 coinsurance.

As shown in the *Evidence of Coverage Snapshot*, the amount of the copayment or coinsurance depends the 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. 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 your insulin is on a tier where cost-sharing is lower than \$35, you will pay the lower cost for your insulins.

Please see Section 7 of this chapter for more information on Part D vaccines cost-sharing.

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* 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.

Please refer to the *Evidence of Coverage Snapshot* for a table that shows your costs for a long-term (60-day or 90-day) supply of a drug. 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 you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,000

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the \$2,000 limit for the Initial Coverage Stage.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,000 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 pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. Refer to the *Evidence of Coverage Snapshot* to see what you will pay during the Catastrophic Coverage Stage.

SECTION 7 Part D Vaccines: What you pay for depends on how and where you get them

Important message about what you pay for vaccines

Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible (if your plan has one). Refer to your plan's Drug List or contact Member Services for coverage and cost-sharing details about specific vaccines.

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 depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.
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 may give the vaccine in the pharmacy or another 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.

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine itself and 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 network 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 of 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.
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) 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 at your pharmacy and then take it to your doctor's office, where they administer the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- When your doctor gives you the vaccine, you may have to 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 coinsurance for the vaccine administration. (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 or drugs

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs**

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. 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 or drugs 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 cost-sharing as discussed in the 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 plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

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

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency services from any provider, whether or not the provider is a part of our network.

In these cases:

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you are owed and pay you back for our share of the cost.

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, such as receipts and bills, 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 *List of Covered Drugs (Formulary)* 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 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. You must submit your claim to us within 12 months of the date you received the service, item, or drug.

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](https://cignamedicare.com/group/maresources)) 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 1004
Nashville, TN 37202

For Part D (Prescription Drugs) Claims

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

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care 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.

The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8:

Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or in other alternate formats, etc.) Debemos proporcionarle la información de manera que la entienda bien y que sea consistente con sus sensibilidades culturales (en idiomas que no sean inglés, en braille, en letra grande o en otros formatos alternativos, 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, or 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 also have some written materials available in Spanish. We can also give you information in braille, in large print, or in 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 Customer Service (phone numbers are printed on the back cover 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.

Su plan tiene la obligación de asegurarse de que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera culturalmente competente y sean accesibles a todos los afiliados, incluidos los que tienen dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o personas con antecedentes culturales y étnicos diversos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la provisión de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder preguntas de los miembros que no hablan inglés. También podemos darle de manera gratuita información en braille, en letra grande o en otros formatos alternativos si lo necesita. Tenemos la obligación de darle la información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para que le proporcionemos información de manera que la entienda bien, llame a Servicio al Cliente.

Nuestro plan debe brindar a las mujeres inscritas la opción de acceder de forma directa a un especialista en salud femenina dentro de la red para los servicios de cuidado médico preventivo y de rutina.

Si dentro de la red del plan no hay disponibilidad de un proveedor para una especialidad, es responsabilidad del plan buscar un proveedor de dicha especialidad fuera de la red que le brinde la atención médica que necesita. En este caso, usted solo pagará los costos compartidos dentro de la red. Si se encuentra en una situación en la que no hay un especialista dentro de la red del plan que cubra un servicio que necesita, llame al plan para pedir información sobre dónde debe ir para obtener dicho servicio dentro de la red, con costos compartidos.

Si tiene algún problema para recibir la información de nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar un reclamo a través de nuestro departamento de Reclamos de los Miembros (los números de teléfono están impresos en la información de contacto de Quejas respecto del cuidado médico en la Sección 1 del Capítulo 2 de este folleto). También puede presentar una queja ante Medicare llamando al 1 800 MEDICARE (1 800 633 4227) o directamente a la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) and behavioral health providers without a referral. 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 persons who are deaf, are hard-of-hearing, and/or have speech and language disorders; simply dial 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. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, go to Chapter 9.

Our plan'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 doctors, 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 and regulatory information, and expert specialist input. Based on these reviews, the committees then vote on which medications, medical and behavioral procedures, and devices to offer that are deemed efficacious and efficient and will provide the greatest benefit for our customers.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we 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, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held at the plan and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made. You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

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

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

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers, including our network pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - To learn more about Cigna Healthcare providers (name, address, professional qualifications, specialty, medical school attended, residency completion, and board certification status), please see our *Provider and Pharmacy Directory*. The most up-to-date version of our *Provider and Pharmacy Directory* is available on our website at [Cignamedicare.com/group/maresources](https://cignamedicare.com/group/maresources).
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.
 - Staff are available to answer utilization management (UM) questions about services or medications that require prior approval or authorization. Staff will identify themselves by name, by title, and as a Cigna Healthcare employee when answering or returning calls regarding UM issues. You may leave a message after normal business hours and Cigna Healthcare will return your call. Call 1-800-558-4314 (TDD/TTY) 8 a.m. – 5 p.m., Monday – Friday or FAX 1-866-730-1896. Language assistance is available.

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 members 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 or stop taking medication, 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 the Attorney General's office 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.

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**. For details, go to Appendix A.
- 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**. For details about this organization and how to contact it, go to Appendix A.
- 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 user should call 1-877-486-2048.

You have the right to make recommendations regarding the Cigna Healthcare 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.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* 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 drug coverage.
- 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 most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **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,” “coverage determination,” or “at-risk determination”; and “independent review organization” instead of “Independent Review Entity.”
- 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 of this document.

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 they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

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

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 10** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service, or other concerns.”**

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we 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 medical care 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 medical care is not covered or is no longer covered by Medicare. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

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

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See Section 5.4 of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6 of this chapter.

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 9 in this chapter explains the Level 3, 4, and 5 appeals processes.)

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

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

- You **can call us at Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the Appointment of Representative form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
 - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
 - 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, a relative, or other person to be your representative, 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.) 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 to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility [CORF] services)

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

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of the document *Medical Benefits Chart (what is covered and what you pay)* and the *Evidence of Coverage Snapshot*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Section 7 and 8 of this Chapter. Special rules apply to these type 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 or 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 items and/or services (not requests for payment for items and/or services already 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 coverage decision or fast coverage decision.

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

Step 3: We consider your request for medical care coverage and give you our answer.***For standard coverage decisions we use the standard deadlines.***

This means we 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 drug**, 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 service. 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 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 an appeal of a fast appeal.

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

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

- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for 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, including 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. (See Section 10 of this chapter for information on complaints.)
 - 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 we have agreed to provide 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 answer is no to part or all of what you requested,** 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 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: The independent review organization reviews your appeal.

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

If you had a “fast appeal” at Level 1, you will also have a “fast appeal” at Level 2.

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

If you had a “standard appeal” at Level 1, you will also have a “standard appeal” at Level 2.

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

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

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

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 and make a third 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal**Section 6.1 This section tells you 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.

Part D coverage decisions and appeals

Legal term

An initial coverage decision about your Part D drugs is called a “**coverage determination.**”

A coverage determination 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 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**
- Getting payment 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 both how to ask for coverage decisions 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.**”
 Asking for removal of a restriction on coverage for a drug is also sometimes called asking for a “**formulary exception.**”
 Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a “**tiering 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 3, 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 four 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. 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.

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

- You cannot ask us to change the cost-sharing tier for any drug in Tier 4, 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, you can ask for another review by making an appeal.

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

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

Step 1: 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 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 your 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 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 24 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 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, your 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 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-888-281-7867 (TTY 711).** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the Medicare Redetermination 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 [CignaHealthcareMedicare.com/forms](https://www.CignaHealthcareMedicare.com/forms).
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for 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 we do not give you a decision within 7 calendar days, 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 appeal process.
- **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 review organization. If, however, we did not complete our review within the applicable timeframe or we made 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 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 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 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 review organization **within 72 hours** after we receive the decision from the 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 review organization.

What if the 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 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 appeals 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 also 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).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you the following:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) 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 (phone numbers are printed on the back cover of this booklet) 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 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 checks to see if your planned discharge date is medically appropriate for you.

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

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

How can you contact this organization?

- The written notice you 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 Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - If you meet this deadline, you 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 contact us. If 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 7.4.

Once you request an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling 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.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 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 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 reviewers will decide on your appeal and tell you their decision.***If the review organization says yes:***

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called “upholding the decision.”
- 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 9 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 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 the appendix of this document.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

Health professionals at the Quality Improvement Organization (the reviewers) will ask you or your representative why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

By the end of the day the reviewers 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, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

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

Section 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 again and ask for another review.

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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 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 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.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D drug 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 value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for 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 answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the administrative law judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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 you need 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, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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.

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

- 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 or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your 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 the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our customer service? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • 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? <ul style="list-style-type: none"> ▫ Examples include waiting too long on the phone, in the waiting or exam room, when getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>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:</p> <ul style="list-style-type: none"> • You asked us 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 or drugs that were approved, you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization, you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms

- A **“complaint”** is also called a **“grievance.”**
- **“Making a complaint”** is **“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.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).
- **Whether you call or write, you should contact Customer Service right away.** 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 reasons 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 to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 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 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. Section 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where 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 prescription drugs 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 happens 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.
 - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- **Your membership will end in our plan** 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 and also, for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the third month of entitlement.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

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

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

- Usually, when you have moved.
- If you have Medicaid.
- If 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.

The enrollment time periods vary depending on your situation.

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

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

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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

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.

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

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

- **Call your plan sponsor.**
- Find more information in the **Medicare & You 2025** 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?

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. • You will automatically be disenrolled from our plan when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from our plan when your new plan's coverage begins.
If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this. • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our plan

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

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will 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 area.)
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- 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 **your plan sponsor**.

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

Cigna Healthcare is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

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

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

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, 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 <https://www.hhs.gov/ocr/index>.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Cigna Healthcare 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.

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.

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (**See "Interchangeable Biosimilar"**).

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 that begins when you (or other qualified parties on your behalf) have spent \$2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

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

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, a hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example, \$10), rather than a percentage.

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four 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 document.

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

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

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.

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 our 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 our plan sponsor requires you to try another drug before receiving the drug you are requesting or if our plan program 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 six months or less. We, your plan, 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 two 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.

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

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

Institutional Special Needs Plan – A 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 facilities may include a skilled nursing facility (SNF), a nursing facility (NF), an SNF/NF, an Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, health care services that are covered under Medicare Part A, Medicare Part B, or Medicaid and whose residents have similar needs and health care status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan – A 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 who reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See “Extra Help.”

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for your Medicare Part A and Part B premiums and for prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

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

Medical Group – An association of primary care providers (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.

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 three-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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare 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.

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, biologics, 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 pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. 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 Biological Product – A biological product that has been approved by the Food and Drug Administration and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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 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 does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. 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 Tier” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Part C – See “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

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.

Preferred Provider Organization (PPO) Plan – 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 (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care provider (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 provider 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 Benefits Chart in the *Evidence of Coverage Snapshot*. Covered drugs that need prior authorization are

marked in the formulary, and our criteria is posted on our website.

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

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

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

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

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include if you move outside the service area, if you 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 – 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 doctor 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 – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual check-ups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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 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, 400 Gambell Street, Suite 303, Anchorage, AK 99501

WEBSITE medicare.alaska.gov**Arizona***State Health Insurance Assistance Program*

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

TTY 711

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 des.az.gov/medicare-assistance**Arkansas***Senior Health Insurance Information Program (SHIIP)*

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

WRITE Senior Health Insurance Information Program (SHIIP), Arkansas Insurance Department, #1 Commerce Way, Suite 102, Little Rock, AR 72202

WEBSITE insurance.arkansas.gov/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 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 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 Aging and Disability Services, 55 Farmington Avenue, Hartford, CT 06105-3730

WEBSITE portal.ct.gov/aginganddisability**Delaware***Delaware Medicare Assistance Bureau (DMAB)*

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

WRITE Delaware Medicare Assistance Bureau (DMAB), Department of Insurance, 1351 West North Street, Suite 101, Dover, DE 19904

WEBSITE insurance.delaware.gov/divisions/dmab

District of Columbia

DC SHIP

CALL 1-202-727-8370
 TTY 711
 WRITE DC SHIP, DC Dept. of Aging and Community
 Living, 250 E Street SW, Washington, DC 20024
 WEBSITE dacl.dc.gov/service/health-insurance-counseling

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 280-S,
 Tallahassee, FL 32399
 WEBSITE floridashine.org

Georgia

Georgia SHIP

CALL 1-866-552-4464 (option #4)
 TTY 1-404-657-1929
 WRITE Georgia SHIP, Georgia Department of
 Human Services, Division of Aging Services,
 2 Peachtree Street NW, Suite 33-101,
 Atlanta, GA 30303
 WEBSITE aging.georgia.gov/georgia-ship

Hawaii

Hawaii SHIP

CALL 1-808 586-7299 or 1-888-875-9229
 TTY 1-866-810-4379
 WRITE Hawaii SHIP, Executive Office on Aging,
 Department of Health, 250 S Hotel Street,
 Suite 406, Honolulu, HI 96813-2831
 WEBSITE hawaiiiship.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
 WEBSITE 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 illinois.gov/aging/SHIP

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
 WEBSITE in.gov/ship

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 Street, 4th Floor,
 Des Moines, IA 50309-3738
 WEBSITE 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 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, Department for Aging and Independent Living, 275 East Main Street, Frankfort, KY 40621

WEBSITE 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, P.O. Box 94214, Baton Rouge, LA 70804-9214

WEBSITE ldi.la.gov/SHIIP**Maine***Maine State Health Insurance Assistance Program (SHIP)*

CALL 1-800-262-2232

TTY 711

WRITE Maine State Health Insurance Program (SHIP), Office of Aging and Disability Services, 11 State House Station, 41 Anthony Avenue, Augusta, ME 04333

WEBSITE maine.gov/dhhs/oads**Maryland***Senior Health Insurance Assistance Program*

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

TTY 711

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

WEBSITE 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

WRITE Serving the Health Insurance Needs of Everyone (SHINE), Executive Office of Elder Affairs, 1 Ashburton Place, 5th Floor, Boston, MA 02108

WEBSITE 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 103, Lansing, MI 48917

WEBSITE 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, 540 Cedar Street, P.O. Box 64976, St. Paul, MN 55164-0976

WEBSITE mn.gov/senior-linkage-line

Mississippi

State Health Insurance Assistance Program (SHIP)

CALL 1-601-359-4577 or 1-844-822-4622
 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 mdhs.ms.gov/aging/finding-services-for-older-adults

Missouri

Missouri SHIP

CALL 1-800-390-3330
 WRITE Missouri SHIP, 601 W Nifong Boulevard, Suite 3A, Columbia, MO 65203-6804
 WEBSITE missouricclaim.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, 1100 N Last Chance Gulch, Helena, MT 59601
 WEBSITE dphhs.mt.gov/sltc/aging/ship

Nebraska

Nebraska SHIP

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, P.O. Box 95087, Lincoln, NE 68509-5087
 WEBSITE doi.nebraska.gov/consumer/senior-health

Nevada

Medicare Assistance Program (MAP)

CALL 1-702-486-3478 or 1-800-307-4444
 WRITE Nevada MAP, Aging and Disability Services Division, 3320 W Sahara Avenue, Suite 100, Las Vegas, NV 89102
 WEBSITE adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog

New Hampshire

NH SHIP - ServiceLink Resource Center

CALL 1-866-634-9412
 TTY 1-800-735-2964
 WRITE NH SHIP-ServiceLink Resource Center, NH DHHS, Bureau of Elderly & Adult Services, 105 Pleasant Street, Gov. Gallan State Office Park S, Concord, NH 03301-3857
 WEBSITE dhhs.nh.gov/programs-services/adult-aging-care/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 807, Trenton, NJ 08625-0807
 WEBSITE 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 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, Agency Building #2 Albany, NY 12223-1251

WEBSITE 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 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, Department 401, Bismarck, ND 58505

WEBSITE 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), Ohio Department of Insurance, 50 W. Town Street, 3rd Floor, Suite 300, Columbus, OH 43215

WEBSITE insurance.ohio.gov**Oklahoma***Senior Health Insurance Counseling Program (SHIP)*

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

WRITE Oklahoma Medicare Assistance Program (MAP), Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105

WEBSITE oid.ok.gov/consumers/information-for-seniors**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), Department of Consumer and Business Services, 350 Winter Street NE, Room 330, Salem, OR 97309-0405

WEBSITE shiba.oregon.gov**Pennsylvania***Pennsylvania Medicare Education and Decision Insight (PA MEDI)*

CALL 1-800-783-7067

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

WEBSITE aging.pa.gov**Puerto Rico***State Health Insurance Assistance Program (SHIP)*

CALL 1-877-725-4300

TTY 1-878-919-7291

WRITE Office for the Ombudsman for the Elderly, P.O. Box 191179, San Juan, PR 00919-1179

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

Rhode Island

Senior Health Insurance Program (SHIP)

CALL 1-888-884-8721
 TTY 1-401-462-0740
 WRITE Senior Health Insurance Program (SHIP),
 Office of Healthy Aging, 25 Howard Ave,
 Building 57, Cranston, RI 02920
 WEBSITE oha.ri.gov

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 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 -2291
 WEBSITE 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, Andrew Jackson Building,
 9th Floor, 502 Deaderick Street,,
 Nashville, TN 37243
 WEBSITE tnmedicarehelp.com

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 Aging and Disability
 Services, 701 West 51st Street, MC: W275,
 Austin, TX 78751
 WEBSITE 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 daas.utah.gov/seniors

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 vermont4a.org

Virginia

Virginia Insurance Counseling & Assistance Program (VICAP)

CALL 1-804 662-9333 or 1-800-552-3402
 TTY 711
 WRITE Virginia Insurance Counseling & Assistance
 Program (VICAP), Department for Aging and
 Rehabilitative Services, 1610 Forest Avenue,
 Henrico, VA 23229
 WEBSITE 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, 5000 Capitol Boulevard, Tumwater, WA 98504-0256

WEBSITE insurance.wa.gov/shiba**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, Room 551, P.O. Box 7851, Madison, WI 53707-7851

WEBSITE dhs.wisconsin.gov/benefit-specialists/ebs.htm**West Virginia***West Virginia SHIP*

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

WRITE West Virginia SHIP West Virginia Bureau of Senior Services, 1900 Kanawha Boulevard East, Charleston, WV 25305-0160

WEBSITE wvship.org**Wyoming***Wyoming State Health Insurance Information Program (WSHIIP)*

CALL 1-800-856-4398

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

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

Appendix B: Quality Improvement Organizations (QIO) contact information

Alabama

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends
 and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite
 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Alaska

Acentra Health

CALL 1-888-305-6759
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends
 and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd.,
 Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Arizona

Livanta

CALL 1-877-588-1123
 TTY 1-855-887-6668
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends
 and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford
 Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Arkansas

Acentra Health

CALL 1-888-315-0636
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends
 and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite
 900, Tampa, FL 33609
 WEBSITE acentraqio.com

California

Livanta

CALL 1-877-588-1123
 TTY 1-855-887-6668
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends
 and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford
 Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Colorado

Acentra Health

CALL 1-888-317-0891
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends
 and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd.,
 Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Connecticut

Acentra Health

CALL 1-888-319-8452
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Delaware

Livanta

CALL 1-888-396-4646
 TTY 1-888-985-2660
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

District of Columbia

Livanta

CALL 1-888-396-4646
 TTY 1-888-985-2660
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Florida

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Georgia

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Hawaii

Livanta

CALL 1-877-588-1123
 TTY 1-855-887-6668
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Idaho

Acentra Health

CALL 1-888-305-6759
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Illinois

Livanta

CALL 1-888-524-9900
 TTY 1-888-985-8775
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Indiana

Livanta

CALL 1-888-524-9900
 TTY 1-888-985-8775
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Iowa

Livanta

CALL 1-888-755-5580
 TTY 1-888-985-9295
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Kansas

Livanta

CALL 1-888-755-5580
 TTY 1-888-985-9295
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Kentucky

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm, Weekends and holidays, 11:00 am–3:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Louisiana

Acentra Health

CALL 1-888-315-0636
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Maine

Acentra Health

CALL 1-888-319-8452
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Maryland

Livanta

CALL 1-888-396-4646
 TTY 1-888-985-2660
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Massachusetts

Acentra Health

CALL 1-888-319-8452
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm, Weekends and holidays, 11:00 am–3:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Michigan

Livanta

CALL 1-888-524-9900
 TTY 1-888-985-8775
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantagio.cms.gov

Minnesota

Livanta

CALL 1-888-524-9900
 TTY 1-888-985-8775
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantagio.cms.gov

Mississippi

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentragio.com

Missouri

Livanta

CALL 1-888-755-5580
 TTY 1-888-985-9295
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantagio.cms.gov

Montana

Acentra Health

CALL 1-888-317-0891
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentragio.com

Nebraska

Livanta

CALL 1-888-755-5580
 TTY 1-888-985-9295
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantagio.cms.gov

Nevada

Livanta

CALL 1-877-588-1123
 TTY 1-855-887-6668
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantagio.cms.gov

New Hampshire

Acentra Health

CALL 1-888-319-8452
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentragio.com

New Jersey

Livanta

CALL 1-866-815-5440
 TTY 1-866-868-2289
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

New Mexico

Acentra Health

CALL 1-888-315-0636
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

New York

Livanta

CALL 1-866-815-5440
 TTY 1-866-868-2289
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

North Carolina

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

North Dakota

Acentra Health

CALL 1-888-317-0891
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Ohio

Livanta

CALL 1-888-524-9900
 TTY 1-888-985-8775
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Oklahoma

Acentra Health

CALL 1-888-315-0636
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Oregon

Acentra Health

CALL 1-888-305-6759
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Pennsylvania

Livanta

CALL 1-888-396-4646
 TTY 1-888-985-2660
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Rhode Island

Acentra Health

CALL 1-888-319-8452
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

South Carolina

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

South Dakota

Acentra Health

CALL 1-888-317-0891
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Tennessee

Acentra Health

CALL 1-888-317-0751
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Texas

Acentra Health

CALL 1-888-315-0636
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Utah

Acentra Health

CALL 1-888-317-0891
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Vermont

Acentra Health

CALL 1-888-319-8452
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Virginia

Livanta

CALL 1-888-396-4646
 TTY 1-888-985-2660
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Wisconsin

Livanta

CALL 1-888-524-9900
 TTY 1-888-985-8775
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

Washington

Acentra Health

CALL 1-888-305-6759
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

Wyoming

Acentra Health

CALL 1-888-317-0891
 TTY 1-855-843-4776
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm
 WRITE Acentra Health, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609
 WEBSITE acentraqio.com

West Virginia

Livanta

CALL 1-888-396-4646
 TTY 1-888-985-2660
 HOURS Monday–Friday, 9:00 am–5:00 pm; weekends and holidays, 10:00 am–4:00 pm.,
 24 hour voicemail service is available
 WRITE Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
 WEBSITE livantaqio.cms.gov

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 am–5:00 pm
 WRITE Alabama Medicaid Agency, P.O. Box 5624,
 Montgomery, AL 36103-5624
 WEBSITE medicaid.alabama.gov

Alaska

State of Alaska Department of Health & Social Services

CALL 1-800-770-5650, opción 2
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 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 am–9:00 pm;
 Saturday, 8:00 am–6:00 pm
 WRITE Arizona Health Care Cost Containment
 System (AHCCCS), 801 E. Jefferson Street,
 Phoenix, AZ 85034
 WEBSITE azahcccs.gov

Arkansas

Arkansas Medicaid

CALL 1-800-482-8988
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–4:30 pm
 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 benefits.gov/benefit/1089

California

Medi-Cal

CALL 1-916 552-9200 or 1-800-541-5555
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Medi-Cal, P.O. Box 997417, MS 4607,
 Sacramento, CA 95899-7417
 WEBSITE 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 am–5:00 pm
 WRITE Health First Colorado, Department of Health
 Care Policy & Financing, 1570 Grant Street,
 Denver, CO 80203
 WEBSITE healthfirstcolorado.com/

Connecticut

Connecticut Department of Social Services

CALL 1-855-626-6632
 TTY 1-800-842-4524
 HOURS Monday–Friday, 7:30 am–4:00 pm
 WRITE Connecticut Department of Social Services,
 25 Sigourney Street, Hartford, CT 06106-5033
 WEBSITE ct.gov/dss

Delaware*Delaware Health & Social Services*

CALL 1-302-255-9500 or 1-800-372-2022
 HOURS Monday–Friday, 7:30 am–4:30 pm
 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 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 am–4:45 pm
 WRITE Department of Health Care Finance, 441 4th Street, NW, 900S, Washington, DC 20001
 WEBSITE dhcf.dc.gov

Florida*Agency For Health Care Administration*

CALL 1-877-711-3662
 TTY 1-866-467-4970
 HOURS Monday – Thursday, 8:00 am–8:00 pm, Friday, 8:00 am–7:00 pm
 WRITE Agency For Health Care Administration, P.O. Box 5197, Tallahassee, FL 32314
 WEBSITE flmedicaidmanagedcare.com

Georgia*Georgia Department of Community Health*

CALL 1-404-657-5468
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Georgia Department of Community Health, 2 Peachtree Street, NW, Atlanta, GA 30303
 WEBSITE medicaid.georgia.gov

Hawaii*Department of Human Services*

CALL 1-800-316-8005
 TTY 1-800-603-1201
 HOURS Monday–Friday, 7:45 am–4:30 pm
 WRITE Department of Human Services, Med-QUEST Division, P.O. Box 700190, Kapolei, HI 96709-0190
 WEBSITE 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 am–5:00 pm
 WRITE Idaho Department of Health and Welfare, 450 W State Street, Boise, ID 83702
 WEBSITE 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 am–4:45 pm
 WRITE Illinois Department of Healthcare and Family Services, 401 South Clinton, Chicago, IL 60607
 WEBSITE 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 am–4:30 pm
 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 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 am–5:00 pm
 WRITE Iowa Medicaid Enterprise, Customer Service,
 P.O. Box 36510, Des Moines, IA 50315
 WEBSITE dhs.iowa.gov/iahealthlink

Kansas

KanCare

CALL 1-800-792-4884
 TTY 1-800-792-4292
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE KanCare, P.O. Box 3599,
 Topeka, KS 66601-9738
 WEBSITE kancare.ks.gov

Kentucky

Cabinet for Health and Family Services

CALL 1-855-306-8959
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Cabinet for Health and Family Services,
 Department for Medicaid Services,
 275 East Main Street, Frankfort, KY 40621
 WEBSITE chfs.ky.gov/agencies/dms/member/Pages/default.aspx

Louisiana

Louisiana Medicaid

CALL 1-888-342-6207
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Louisiana Medicaid, Department of
 Health and Hospitals, P.O. Box 629,
 Baton Rouge, LA 70821-0629
 WEBSITE dhh.louisiana.gov

Maine

Office of MaineCare Services

CALL 1-855-797-4357
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Office of MaineCare Services, 11 State House
 Station, Augusta, ME 04333-0011
 WEBSITE 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 am–5:00 pm
 WRITE Medicaid/Medical Assistance, Maryland
 Department of Health & Mental Hygiene,
 201 West Preston Street, Baltimore, MD 21201
 WEBSITE 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 am–5:00 pm
 WRITE Office of Medicaid, One Ashburton Place,
 11th Floor, Boston, MA 02108
 WEBSITE 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 am–5:00 pm
 WRITE Michigan Department of Health & Human
 Services, 333 S. Grand Avenue,
 P.O. Box 30195, Lansing MI 48909
 WEBSITE michigan.gov/mdhhs

Appendix C: State Medicaid Agencies contact information**Minnesota***Minnesota Department of Human Services*

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

TTY 711.0

HOURS Monday–Friday, 8:00 am–4:30 pm

WRITE Medical Assistance (MA), Minnesota
Department of Human Services,
P.O. Box 64989, St. Paul, MN 55164WEBSITE mn.gov/dhs**Mississippi***Mississippi Division of Medicaid*

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

HOURS Monday–Friday, 7:30 am–5:00 pm

WRITE Mississippi Division of Medicaid, Sillers
Building, 550 High Street, Suite 1000,
Jackson, MS 39201-1399WEBSITE 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 am–5:00 pm

WRITE The State of Missouri, MO HealthNet Division,
615 Howerton Court, P.O. Box 6500,
Jefferson City, MO 65102-6500WEBSITE 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 am–5:00 pm

WRITE Department of Public Health & Human
Services, Health Resources Division,
P. O. Box 202951, Helena, MT 59620-2951WEBSITE 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 am–5:00 pm

WRITE Nebraska Department of Health and Human
Services, Division of Medicaid & Long-Term
Care, P.O. Box 95026, Lincoln, NE 68509-5026WEBSITE dhhs.ne.gov**Nevada***Nevada Department of Health and Human Services*

CALL 1-877-638-3472

HOURS Monday–Friday, 9:00 am–5:00 pm

WRITE Nevada Department of Health and Human
Services, Division of Health Care Financing
and Policy, 1100 E. William Street, Suite 111,
Carson City, NV 89701WEBSITE 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 am–4:30 pm

WRITE Office of Medicaid Business & Policy, NH
Department of Health and Human Services,
129 Pleasant Street, Concord, NH 03301WEBSITE dhhs.nh.gov**New Jersey***NJ Department of Human Services*

CALL 1-800-356-1561

HOURS Monday–Friday, 8:00 am–5:00 pm

WRITE NJ Department of Human Services, Division
of Medical Assistance and Health Services,
P.O. Box 712, Trenton, NJ 08625-0712WEBSITE 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 am–5:00 pm
 WRITE NM Human Services Department's Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504-2348
 WEBSITE 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 am–4:45 pm
 WRITE New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237
 WEBSITE 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 am–5:00 pm
 WRITE NC Division of Medical Assistance, 2501 Mail Service Center, Raleigh, NC 27699-2501
 WEBSITE 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 am–5:00 pm
 WRITE Medical Services Division, North Dakota Department of Human Services, 600 E. Boulevard Avenue, Dept 325, Bismarck, ND 58505-0250
 WEBSITE nd.gov/dhs

Ohio

Ohio Department of Medicaid
 CALL 1-800-324-8680
 TTY 1-800-292-3572
 HOURS Monday–Friday, 8:00 am–5:00 pm, Saturday – Sunday, 8:00 am–5:00 pm
 WRITE Ohio Department of Medicaid, 50 West Town Street, Suite 400, Columbus, OH 43215
 WEBSITE 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 am–5:30 pm
 WRITE Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105
 WEBSITE 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 am–5:00 pm
 WRITE Oregon Health Plan, Health Systems Division, 500 Summer Street NE, Salem, OR 97301-1079
 WEBSITE oregon.gov/OHA/healthplan

Pennsylvania

Pennsylvania Department of Human Services
 CALL 1-800-692-7462
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–4:45 pm
 WRITE Pennsylvania Department of Human Services, Office of Medical Assistance Programs, P.O. Box 2675, Harrisburg, PA 17105-2675
 WEBSITE 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 am–4:00 pm

WRITE Rhode Island Department of Human Services,
Louis Pasteur Building, 600 New London
Avenue, Cranston, RI 02921WEBSITE 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 am–6:00 pm,
Saturday, 9:00 am–12:00 pmWRITE Department of Health and Human Services,
South Carolina Health Connections Medicaid,
P.O. Box 8206, Columbia, SC 29202WEBSITE 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 am–5:00 pm

WRITE South Dakota Department of Social Services,
Division of Medical Services, 700 Governors
Drive, Pierre, SD 57501WEBSITE dss.sd.gov/medicaid**Tennessee***TennCare*

CALL 1-800-342-3145

TTY 1-877-779-3103

HOURS Monday–Friday, 7:00 am–6:00 pm

WRITE TennCare, 310 Great Circle Road,
Nashville, TN 37243WEBSITE 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 am–5:30 pm

WRITE Texas Health and Human Services
Commission, Brown-Heatly Building, 4900 N.
Lamar Boulevard, Austin, TX 78751-2316WEBSITE yourtexasbenefits.hhsc.texas.gov**Utah***Utah Department of Health*

CALL 1-801-538-6155 or 1-800-662-9651

HOURS Monday–Friday, 8:00 am–5:00 pm

WRITE Utah Department of Health, Division of
Medicaid and Health Financing, P.O. Box
143106, Salt Lake City, UT 84114-3106WEBSITE medicaid.utah.gov**Vermont***Green Mountain Care*

CALL 1-800-250-8427

TTY 711.0

HOURS Monday–Friday, 8:00 am–8:00 pm

WRITE Green Mountain Care, Department of
Vermont Health Access, 280 State Dr.,
Waterbury, VT 05671WEBSITE greenmountaincare.org

Virginia

Department of Medical Assistance Services
CALL 1-804-786-7933
TTY 1-800-343-0634
HOURS Monday–Friday, 8:00 am–5:00 pm
WRITE Department of Medical Assistance Services,
Attn: Director’s Office, 600 East Broad Street,
Richmond, VA 23219
WEBSITE dmas.virginia.gov

Washington

Washington Apple Health (Medicaid)
CALL 1-800-562-3022
TTY 711.0
HOURS Monday–Friday, 7:00 am–5:00 pm
WRITE Washington Apple Health (Medicaid),
P.O. Box 45531, Olympia, WA 98504
WEBSITE 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 am–5:00 pm
WRITE West Virginia Bureau for Medical Services,
350 Capitol Street, Room 251,
Charleston, WV 25301
WEBSITE 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 am–4:30 pm
WRITE Department of Health Services,
1 West Wilson Street, Madison, WI 53703
WEBSITE 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 am–5:00 pm
WRITE Wyoming Medicaid, 6101 Yellowstone Road,
Suite 210, Cheyenne, WY 82009
WEBSITE 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 am–4:30 pm
 WRITE Chronic Renal Disease Program (CRDP),
 Delaware Health and Social Services (DHSS),
 13 S.W. Front Street, Milford, DE 19963
 WEBSITE dhss.delaware.gov/dhss/dmma/crdprog.html

Delaware

Delaware Prescription Assistance Program

CALL 1-800-996-9969
 HOURS Monday–Friday, 8:00 am–4:30 pm
 WRITE DPAP, P.O. Box 950, New Castle, DE 19720
 WEBSITE dhss.delaware.gov/dhss/dmma/dpap.html

Indiana

HoosierRx

CALL 1-866-267-4679
 HOURS Monday–Friday, 7:00 am–3:00 pm
 WRITE HoosierRx, P.O. Box 6224,
 Indianapolis, IN 46206
 WEBSITE gov/medicaid/members/member-programs/hoosierx

Maine

Maine DEL

CALL 1-866-796-2463
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–4:30 pm
 WRITE Office for Family Independence, State
 of Maine-- DHHS, 114 Corn Shop Lane,
 Farmington, ME 04938-9900
 WEBSITE maine.gov/dhhs/oms/mainecare-options/limited-benefits

Massachusetts

Prescription Advantage

CALL 1-800-243-4636
 TTY 1-877-610-0241
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Prescription Advantage, P.O. Box 15153,
 Worcester, MA 01615-0153
 WEBSITE mass.gov/prescription-drug-assistance

Maryland

Maryland - SPDAP

CALL 1-800-551-5995
 TTY 1-800-877-5156
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Maryland - SPDAP, c/o International Software
 Systems Inc., PO Box 749, Greenbelt, MD
 20768-0749
 WEBSITE marylandspdap.com

Montana

Big Sky Rx Program

CALL 1-866-369-1233
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Big Sky Rx Program, P.O. Box 202915,
 Helena, MT 59620-2915
 WEBSITE dphhs.mt.gov/MontanaHealthcarePrograms/BigSky

Montana

Montana Mental Health Services Plan (MHSP)

CALL 1-406-443-7871
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 am–5:00 pm
 WRITE Nevada Senior Rx, 1860 E. Sahara Avenue,
 Las Vegas, NV 89104
 WEBSITE [adssd.nv.gov/Programs/Seniors/SeniorRx/
 SrRxProg](https://adssd.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 [state.nj.us/humanservices/doas/ services/paad](https://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 am–5:00 pm
 WRITE EPIC, P.O. Box 15018, Albany, NY 12212-5018
 WEBSITE 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 am–5:00 pm
 WRITE Rx for Oklahoma Prescription Assistance,
 Oklahoma Department of Commerce,
 900 N. Stiles Ave., Oklahoma City, OK 73104
 WEBSITE [oid.ok.gov/consumers/information-for-seniors/
 senior-health-insurance-counseling- program-
 ship/low-income-subsidy-lis-for- prescription-
 drugs](https://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 am–5:00 pm
 WRITE Pharmaceutical Assistance Contract for the
 Elderly (PACE), P.O. Box 8806,
 Harrisburg, PA 17105
 WEBSITE [aging.pa.gov/aging-services/ prescriptions/
 Pages/default.aspx](https://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 am–5:00 pm
 WRITE PACE Needs Enhancement Tier (PACENET),
 P.O. Box 8806, Harrisburg, PA 17105
 WEBSITE [aging.pa.gov/aging-services/prescriptions/
 Pages/default.aspx](https://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 am–5:00 pm
 WRITE Special Pharmaceutical Benefits Program-
 Mental Health, Department of Human Services
 OMHSAS, Commonwealth Tower 12th Floor,
 P.O. Box 2675, Harrisburg, PA 17105-2675
 WEBSITE 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 am–5:00 pm
 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 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 am–4:00 pm
 WRITE Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE), 57 Howard Avenue, Louis Pasteur Building, Cranston, RI 02920
 WEBSITE oha.ri.gov

Texas

Kidney Health Care Program

CALL 1-512-776-7150 or 1-800-222-3986
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Kidney Health Care Program, Specialty Health Care Services, MC 1938, P.O. Box 149347, Austin, TX 78714
 WEBSITE 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 am–5:00 pm
 WRITE Green Mountain Care, VPharm, Health Access Customer Service, Department of Vermont Health Access, 312 Hurricane Lane, Williston, VT 05495
 WEBSITE greenmountaincare.org/prescription

Wisconsin

SeniorCare

CALL 1-800-657-2038
 HOURS Monday–Friday, 8:00 am–6:00 pm
 WRITE SeniorCare, P.O. Box 6710, Madison, WI 53716-0710
 WEBSITE dhs.wisconsin.gov/seniorcare

Wisconsin

Wisconsin Chronic Renal Disease Program

CALL 1-800-362-3002
 HOURS Monday–Friday, 8:30 am–4:30 pm
 WRITE Wisconsin Chronic Renal Disease Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
 WEBSITE dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Hemophilia Home Care Program

CALL 1-800-362-3002
 HOURS Monday–Friday, 8:30 am–4:30 pm
 WRITE Wisconsin Hemophilia Home Care Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
 WEBSITE dhs.wisconsin.gov/forwardhealth/wcdp.htm

Wisconsin

Wisconsin Adult Cystic Fibrosis Program

CALL 1-800-362-3002
 HOURS Monday–Friday, 8:30 am–4:30 pm
 WRITE Wisconsin Adult Cystic Fibrosis Program, Wisconsin Chronic Disease Program, Attn: Eligibility Unit, P.O. Box 6410, Madison, WI 53716-0410
 WEBSITE 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 am–5:00 pm
 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 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 am–5:00 pm
 WRITE Alaskan AIDS Assistance Program,
 1057 W. Fireweed Lane, Anchorage, AK 99503
 WEBSITE alaskanids.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 am–5:00 pm
 WRITE Arizona AIDS Drug Assistance Program,
 Arizona Department of Health, 150 North 18th
 Avenue, Suite 130, Phoenix, AZ 85007
 WEBSITE 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 am–4:30 pm
 WRITE Arkansas AIDS Drug Assistance Program,
 Arkansas Department of Health, 4815 W.
 Markham, Little Rock, AR 72205
 WEBSITE [healthy.arkansas.gov/programs-services/topics/
ryan-white-program](http://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 am–5:00 pm
 WRITE California AIDS Drug Assistance Program,
 CDPH, P.O. Box 997426, Mail Stop 7704,
 Sacramento, CA 95899
 WEBSITE [cdph.ca.gov/Programs/CID/DOA/Pages/
OAadap.aspx](http://cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx)

Colorado

Bridging the Gap, Colorado

CALL 1-303-692-2783
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Bridging the Gap, Colorado-3835,
 4300 Cherry Creek Dr. South,
 Denver, CO 80246-1530
 WEBSITE [cdphe.colorado.gov/state-drug-assistance-
program](http://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 am–4:00 pm
 WRITE Connecticut AIDS Drug Assistance Program,
 Connecticut Department of Public Health,
 410 Capitol Avenue, P.O. Box 340308,
 Hartford, CT 06134
 WEBSITE 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 am–4:30 pm
 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 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 am–4:45 pm
 WRITE DC AIDS Drug Assistance Program, District
 of Columbia Department of Health, 899 North
 Capitol Street NE, Washington, DC 20002
 WEBSITE 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 am–5:00 pm
 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 floridahealth.gov/diseases-and-conditions/aids/adap/index.html

Georgia

Georgia AIDS Assistance Program

CALL 1-404-463-0416
 HOURS Monday–Friday, 9:00 am–5:00 pm
 WRITE Georgia AIDS Assistance Program, Georgia
 Department of Public Health, 2 Peachtree
 Street NW, 15th Floor, Atlanta, GA 30303-3186
 WEBSITE dph.georgia.gov/adap-program

Hawaii

Hawaii AIDS Drug Assistance Program

CALL 1-808-733-9360
 HOURS Monday–Friday, 7:45 am–4:30 pm
 WRITE Hawaii AIDS Drug Assistance Program,
 Hawaii Department of Health, Harm Reduction
 Services Branch, 3627 Kilauea Avenue,
 Suite 306 Honolulu, HI 96816
 WEBSITE 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 am–5:00 pm
 WRITE Idaho AIDS Drug Assistance Program, Ryan
 White Part B Program, 450 W. State Street,
 P.O. Box 83720 Boise, ID 83720-0036
 WEBSITE 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 am–5:00 pm
 WRITE Illinois AIDS Drug Assistance Program,
 Illinois Department of Public Health, Illinois
 ADAP Office, 525 West Jefferson Street,
 Springfield, IL 62761
 WEBSITE 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 am–4:30 pm
 WRITE Indiana AIDS Drug Assistance Program,
 Indiana State Department of Health, 2 North
 Meridian Street, Indianapolis, IN 46204
 WEBSITE 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 am–4:30 pm
 WRITE Iowa AIDS Drug Assistance Program, Iowa
 Department of Public Health, 321 E. 12th
 Street, Des Moines, IA 50319-0075
 WEBSITE idph.iowa.gov/hivstdhep/hiv

Kansas

Kansas AIDS Drug Assistance Program

CALL 1-785-296-6174
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Kansas AIDS Drug Assistance Program,
 Kansas Department of Health and
 Environment, 1000 SW Jackson,
 Suite 210, Topeka, KS 66612
 WEBSITE 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 am–4:30 pm
 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 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 am–5:00 pm
 WRITE Louisiana Drug Assistance Program (L-DAP),
 Louisiana Health Access Program (LA HAP),
 1450 Poydras St. , Suite 2136, New Orleans,
 LA 70112
 WEBSITE lahap.org

Maine

Maine AIDS Drug Assistance Program

CALL 1-207-287-3747
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 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 am–4:30 pm
 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 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 am–5:00 pm
 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 crine.org/hdap

Michigan

Michigan Drug Assistance Program

CALL 1-888-826-6565
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 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 am–4:30 pm
 WRITE Minnesota AIDS Drug Assistance Program, Minnesota Department of Human Services, HIV/ AIDS Division, P.O. Box 64972, St. Paul, MN 55164-0972
 WEBSITE 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 am–5:00 pm
 WRITE Mississippi AIDS Drug Assistance Program, Mississippi State Department of Health, Office of STD/HIV, P.O. Box 1700, Jackson, MS 39215
 WEBSITE 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 am–5:00 pm
 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 health.mo.gov/living/healthcondiseases/communicable/hiv aids/casemgmt.php

Montana

Montana AIDS Drug Assistance Program

CALL 1-406-444-4744
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog

Nebraska

Nebraska AIDS Drug Assistance Program

CALL 1-402-471-2101
 HOURS Monday – Thursday, 8:00 am–5:00 pm, Friday, 9:00 am–3:30 pm
 WRITE Nebraska AIDS Drugs Assistance Program, Ryan White Program, P.O. Box 95206, Lincoln, NE 68509-5026
 WEBSITE dhhs.ne.gov/Documents/RyanWhiteAIDSdrugAssistanceProgram.pdf

Nevada

Nevada AIDS Drug Assistance Program

CALL 1-775-684-4056
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Nevada AIDS Drug Assistance Program, Nevada Division of Public and Behavioral Health, 4126 Technology Way, Suite 200, Carson City, NV 89706
 WEBSITE 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 am–5:00 pm
 WRITE New Hampshire AIDS Drug Assistance Program, New Hampshire Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301-3852
 WEBSITE 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 am–5:00 pm
 WRITE New Jersey AIDS Drug Distribution Program (ADDP), New Jersey Department of Health, P.O. Box 360, Trenton, NJ 08625
 WEBSITE 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 am–5:00 pm
 WRITE New Mexico AIDS Drug Assistance Program, 1190 S. St. Francis Drive, Santa Fe, NM 87505
 WEBSITE 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 am–5:00 pm
 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 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 am–5:00 pm
 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 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 am–5:00 pm
 WRITE North Dakota Department of Health, HIV/AIDS Program, 2635 East Main Ave., Bismarck, ND 58506-5520
 WEBSITE ndhealth.gov/hiv

Ohio

Ohio HIV Drug Assistance Program

CALL 1-800-777-4775
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Ohio HIV Drug Assistance Program,
 Ohio Department of Health, HIV Care
 Services Section, 246 North High Street,
 Columbus, OH 43215
 WEBSITE 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 am–5:00 pm
 WRITE Oklahoma State Department of Health, 1000
 NE 10th, Room 614, Oklahoma City, OK 73117
 WEBSITE oklahoma.gov/health.html

Oregon

CAREAssist

CALL 1-971-673-0144 or 1-800-805-2313
 TTY 711.0
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE CAREAssist, Oregon Health Authority, 800 NE
 Oregon Street, Suite 1105, Portland, OR 97232
 WEBSITE 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 am–4:30 pm
 WRITE Special Pharmaceutical Benefits Program,
 Pennsylvania Department of Health, 625
 Forster St., H&W Bldg., Rm 611, Harrisburg,
 PA 17120
 WEBSITE health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx

Puerto Rico

MC-21

CALL (787) 286-6032
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 am–4:30 pm
 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 health.ri.gov/diseases/hiv aids/about/stayinghealthy/

South Carolina

South Carolina AIDS Drug Assistance Program

CALL 1-800-856-9954
 HOURS Monday–Friday, 8:30 am–5:00 pm
 WRITE South Carolina AIDS Drug Assistance Program, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201
 WEBSITE 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 am–5:00 pm
 WRITE Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th St., Pierre, SD 57501-1700
 WEBSITE doh.sd.gov/diseases/infectious/ryanwhite

Tennessee

Tennessee HIV Drug Assistance Program (HDAP)

CALL 1-615-532-2392
 HOURS Monday–Friday, 8:00 am–5:00 pm
 WRITE Tennessee HIV Drug Assistance Program (HDAP), Tennessee Department of Health, 710 James Robertson Parkway, Andrew Johnson Tower, Nashville, TN 37243
 WEBSITE 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 am–5:00 pm
 WRITE Texas HIV Medication Program, MSJA, MC 1873, P.O. Box 149347, Austin, TX 78714-9347
 WEBSITE dshs.texas.gov/hivstd/meds

Utah

Utah AIDS Drug Assistance Program

CALL 1-801-538-6397
 HOURS Monday–Friday, 8:00 am–5:00 pm
 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 ptc.health.utah.gov/treatment/ryan-white

Vermont

Vermont Medication Assistance Program (VMAP)

CALL 1-802-951-4005
 HOURS Monday–Friday, 8:00 am–4:30 pm
 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 am–6:00 pm, Tuesday, Thursday and Friday, 8:00 am–5:00 pm
 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 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 am–5:00 pm
WRITE Early Intervention Program (EIP),
Washington State Department of Health,
P.O. Box 47841, Olympia, WA 98504-7841
WEBSITE 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 am–4:30 pm
WRITE West Virginia AIDS Drug Assistance Program,
West Virginia Department of Health and
Human Resources, 350 Capital Street, Room
125, Charleston, WV 25301
WEBSITE oepe.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 am–4:30 pm
WRITE Wisconsin AIDS/HIV Drug Assistance Program,
Wisconsin Department of Health Services,
Attn: ADAP, P.O. Box 2659, Madison, WI
53701-2659
WEBSITE 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 am–5:00 pm
WRITE Wyoming AIDS Drug Assistance Program,
Wyoming Department of Health,
6101 Yellowstone Road, Suite 510,
Cheyenne, WY 82002
WEBSITE health.wyo.gov/publichealth/communicable-disease-unit/hiv/aids

Multi-language Interpreter Services

English – ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call **1-888-281-7867** (TTY 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-281-7867** (TTY 711).

Chinese – 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-281-7867** (TTY 711)。

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-281-7867** (TTY 711).

French Creole – ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-281-7867** (TTY 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-281-7867** (TTY 711)번으로 전화해 주십시오.

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-888-281-7867** (TTY 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-281-7867** (ATS 711).

Arabic – ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-281-7867** (TTY 711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-281-7867** (телетайп 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-281-7867** (TTY 711).

Farsi/Persian – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-281-7867** (TTY: 711) تماس بگیرید.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-281-7867** (TTY 711).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-281-7867** (TTY 711).

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-281-7867** (TTY 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-281-7867** (TTY 711)まで、お電話にてご連絡ください。

Navajo – Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiił'eh, éí ná hóló, kóíł' hódíłnih **1-888-281-7867** (TTY 711).

Gujarati – ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-281-7867** (TTY 711).

Urdu توجه دیں: اگر آپ اردو زبان بولتے ہیں تو آپ کے لئے زبان معاون خدمات مفت میں دستیاب ہیں۔ کال کریں **1-888-281-7867** (TTY 711)

Cigna Healthcare Preferred Medicare (HMO) 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, seven days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and 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, seven days a week, 8 a.m. – 8 p.m. local time. April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time
WRITE	Cigna Healthcare Medicare Services, Attn: Medicare Customer Service, P.O. Box 29030, Phoenix, AZ 85038
VISIT	CignaHealthcaremedicare.com/group/maresources

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PFA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE, are owned by Cigna Intellectual Property, Inc. Subsidiaries of The Cigna Group contract with Medicare to offer Part D Prescription Drug Plans (PDPs) in select states. Enrollment in a Cigna Healthcare product depends on contract renewal. © 2025 Cigna Healthcare