

Legal Terms	A "fast" review (or "fast appeal") is also called an "expedited appeal."
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Step 1: Contact our plan and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

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

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would your coverage ends, then **you will have to pay the full cost of this care yourself**.

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity ." It is sometimes called the " IRE ."
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, 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	A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."
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- **If the Administrative Law Judge says yes to your appeal, the appeals process *may or may not be over*** – We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge'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 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. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not be over*** – We will

decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals 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 Medicare Appeals 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 might be able to continue to the next level of the review process. If the Medicare Appeals 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. If the rules allow you to go on, the written notice 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.
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- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

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



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1	What kinds of problems are handled by the complaint process?
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This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems, you can
“make a complaint”****Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for “making a complaint” is “filing a grievance”

**Legal
Terms**

- What this section calls a "**complaint**" is also called a "**grievance.**"
- Another term for "**making a complaint**" is "**filing a grievance.**"
- Another way to say "**using the process for complaints**" is "**using the process for filing a grievance.**"

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You can reach Member Services at (866) 422-5009. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. TTY users should call (877) 907-2985 (TTY). Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
- **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, put your complaint in writing, we will respond to your complaint in writing.

- **Standard Grievances**

To use our formal procedures for answering Grievances, you may call Member Services to submit a verbal grievance or you may forward your Grievance in written form to our address noted in Chapter 2, Section 1.

We will send you a letter notifying you of receipt of your grievance. Once we receive your grievance, we will research your complaint. We may contact you also to ask for additional information.

Once we reach a conclusion, we will notify you verbally or by written correspondence if your request is received in writing, if you request a written response, or if your complaint involves quality of care concerns. Our conclusion should reach you within thirty (30) calendar days of receipt of your grievance. However, some cases require additional time. In those cases, we will notify you of our need for an additional fourteen (14) calendar days to reach a conclusion.

- **Expedited Grievances**

You may file an expedited grievance orally or in writing should you disagree with our decision not to conduct an expedited organization/Coverage Determination or an expedited reconsideration/redetermination. You may also file an expedited grievance if you disagree with the plan's decision to request a fourteen (14) calendar day extension to make a decision on an organization determination, coverage determination or reconsideration. You may request an expedited grievance by contacting Member Services at (866) 422-5009. When an expedited grievance is requested, we are required to provide a response within 24 hours.

- An expedited Grievance must be reviewed and resolved within 24 hours. Expedited Grievances are responded to verbally (by phone) and written notification is sent within 3 calendar days.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or 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.

Legal Terms	What this section calls a " fast complaint " is also called an " expedited grievance. "
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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. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 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 do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4	You can also make complaints about quality of care to the Quality Improvement Organization
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - 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.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on 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.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period
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You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7 in 2011.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can 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. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

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

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medicaid.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can call **Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You 2012* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3	How do you end your membership in our plan?
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Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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 Advantage 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.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ◦ Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet). • 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 through our plan

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

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

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

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

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

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

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services 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 intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- 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.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call Member Services for more information (phone numbers are on the back cover of this booklet).

Section 5.2 We <u>cannot</u> ask you to leave our plan for any reason related to your health
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What should you do if this happens?

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

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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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 make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

Chapter 9. Legal notices

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SECTION 2 Notice about nondiscrimination 125

SECTION 1 **Notice about governing law**

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this 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.

SECTION 2 **Notice about nondiscrimination**

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. 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, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Chapter 10. Definitions of important words

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

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

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. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of our plan, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.4 for more information about balance billing.

Benefit Period – The way that our plan and Original Medicare measures your use of long-term acute care (LTAC) and skilled nursing facility (SNF) services. A benefit period begins the day you go into a long-term acute care facility (LTAC) or skilled nursing facility (SNF). The benefit period ends when you haven't received any LTAC care (or skilled care in a SNF) for 60 days in a row. If you go into a LTAC or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

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

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2)

any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use in this EOC 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 that can be provided by people who don't have professional skills or training, such as 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.

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

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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, loss of a limb, or loss of function of a limb. 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) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

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

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

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

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

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

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Low Income Subsidy – See “Extra Help.”

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. 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.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2011.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Provider – “Provider” is the general term we use 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. We call them “**network providers**” when they 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. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged 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 or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services received is also referred to as the member’s “out-of-pocket” cost requirement.

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

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

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received

from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care Physician (PCP) – Your Primary Care Physician is 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. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your Primary Care Physician before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. 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 may disenroll you if you 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 skilled nursing facility 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 drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration 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 Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

Appendix A - CONTACT TABLES

SHIP - State Health Insurance Assistance Program

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Alabama	Alabama Department of Senior Services	Alabama Department of Senior Services 770 Washington Avenue RSA Plaza Suite 570 Montgomery, Alabama 36130 (334) 242-5743 1-(877)-425-2243 1-800-AGELINE (1-800-243-5463) Fax (334) 242-5594	http://www.alabamaageline.gov/
Arkansas	Arkansas Senior Health Insurance Information Program	1200 West Third Street Little Rock, AR 72201 (501) 371-2600 (800) 282-9134 (501) 371-2618 fax	http://insurance.arkansas.gov/seniors/homepage.htm
Arizona	Arizona Department of Economic Security - Division of Aging and Adult Services	(800) 432-4040	https://www.azdes.gov/common.aspx?menu=36&menuc=28&id=190
California	California Department of Aging	Legal Services of Northern California 3950 Industrial Blvd., Suite 500 West Sacramento, CA 95691 1-800-434-0222 TTY (800) 735-2929	http://www.aging.ca.gov/information_on/hicap.asp
Colorado	Division of Insurance	1560 Broadway, Suite 850, Denver, CO 80202 888-696-7213 En Espanol 866-665-9668	http://www.dora.state.co.us/insurance/senior/senior.htm

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State	Agency Name	Contact Information	Web Site
Connecticut	Aging Services Division	Department of Social Services Aging Services Division 25 Sigourney Street, 10th Floor Hartford, CT 06106 Phone (860) 424-5274 Toll Free (in State) 1-866-218-6631 Fax (860) 424-5301	http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032
Delaware	ELDERinfo	841 Silver Lake Blvd. Dover, DE 19904 (302) 674-7300	http://www.delawareinsurance.gov/departments/elder/eldindex.shtml
Florida	Serving Health Insurance Needs of Elders (SHINE)	Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000 800-963-5337 TDD 1-800-955-8770 TTY 1-800-955-8771	http://www.floridashine.org/
Georgia	GeorgiaCares	DHS Division of Aging Services Two Peachtree Street, NW Suite 9-385 Atlanta, Georgia 30303-3142 Phone: 404.657.5258 Fax: 404.657.5285 Toll Free: 1-866-55-AGING or 1-866-552-4464	http://aging.dhr.georgia.gov/portal/site
Iowa	Senior Health Insurance Information Program of Iowa (SHIP)	330 Maple St. Des Moines, IA 50319-0065 1-800-351-4664 TDD: 1-800-735-2942	http://www.shiip.state.ia.us/

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Idaho	SHIBA Health	Department of Insurance 700 West State Street P.O. Box 83720 Boise, ID 83720-0043 208-334-4250	http://www.doi.idaho.gov/shiba/shwelcome.aspx
Illinois	Senior Health Insurance Program	320 W. Washington Street Springfield, IL 62767 800-548-9043 TDD: 217-524-4872	http://insurance.illinois.gov/ship/
Indiana	State Health Insurance Information Program (SHIIP)	714 West 53rd Street Anderson, Indiana, 46013 1-800-452-4800 TDD: 1-866-846-0139	http://www.in.gov/idoi/2495.htm
Kansas	Senior Health Insurance Counseling For Kansas	1-800-860-5260	http://www.agingkansas.org/SHICK/shick_index.html
Kentucky	State Health Insurance Assistance Program	1-877-293-7447 National: 502-564-6930 TDD: 1-888-642-1137	http://www.chfs.ky.gov/dail/ship.htm
Louisiana	Senior Health Insurance Information Program	1702 N. Third Street P.O. Box 94214 Baton Rouge, LA 70802 1-800-259-5300	http://www.lda.la.gov/Health/SHIIP/index.html
Massachusetts	Serving Health Information Needs of Elders (SHINE)	Executive Office of Elder Affairs One Ashburton Place, Fifth floor Boston, Massachusetts 02108 617-727-7750 800-243-4636 (nationwide) 800-872-0166 (TTY) 617-727-9368 (FAX)	http://www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Elders

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Maryland	Department of Aging	301 West Preston Street Suite 1007 Baltimore, MD 21201 Phone: (410) 767-1100 Toll free, Maryland: 1-800-243-3425 Fax: (410) 333-7943 Maryland relay service: 1-800-201-7165	http://www.aging.maryland.gov/senior.html
Maine	State Health Insurance Assistance Program	Office of Elder Services Maine Department of Health and Human Services 11 State House Station 32 Blossom Lane Augusta, ME 04333 (207) 287-9200 (800) 262-2232 Fax: (207)287-9229 TTY: (800)606-0215	http://www.maine.gov/dhhs/oes/hiap/index.shtml
Michigan	Michigan Medicare Medicaid Assistance Program	6105 West St. Joseph, Suite 204 Lansing, MI. 48917-4850 (800) 803-7174	http://www.mmapinc.org/
Missouri	CLAIM	800-390-3330	http://www.missouricclaim.org/
Mississippi	Division of Aging & Adult Services	750 North State St., Jackson, MS 39202 (601)359-4500 (800) 345-6347	http://www.mdhs.state.ms.us/aas_info.html#MICAP
Montana	State Health and Insurance Assistance Program SHIP	800-332-2272	http://www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml
North Carolina	North Carolina Department of Insurance	Seniors' Health Insurance Information Program 11 South Boylan Avenue Raleigh, NC 27603 800-443-9354 919-807-6900 Fax: 919-807-6901 Email: ncship@ncdoi.gov	http://www.ncdoi.com/SHIIP/Default.aspx

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
North Dakota	State Health Insurance Counseling Program (SHIC)	North Dakota Insurance Department State Capitol, fifth floor 600 E. Boulevard Ave. Bismarck, ND 58505-0320 701.328.2440 701.328.4880 fax 888.575.6611 toll free 800.366.6888 TTY line	http://www.nd.gov/ndins/consumer/shic/
Nebraska	Nebraska Senior Health Insurance Information Program (SHIIP)	Nebraska Department of Insurance Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690 (402) 471-2201 (800) 234-7119 TDD (800) 833-7352 VOICE (800) 833-0920 (Nebraska Relay Service Voice option)	http://www.doi.ne.gov/shiip/
New Hampshire	ServiceLink	2 Industrial Park Drive, P.O. Box 1016 Concord, NH 03302-1016 866-634-9412	http://www.nh.gov/service-link/
New Jersey	State Health Insurance Assistance Program (SHIP)	P. O. Box 360 Trenton, NJ 08625-0360 800-792-8820	http://www.state.nj.us/health/senior/ship.shtml
New Mexico	Aging and Long-Term Services	Parks Building 1015 Tijeras NW, Suite 200 Albuquerque, New Mexico 87102 505-222-4500 866-842-9230	http://www.nmaging.state.nm.us/
Nevada	State Health Insurance Assistance Program	3416 Goni Road Suite D-132 Carson City, NV 89706 800-307-4444 En Espanol: (702) 759-0874	http://www.nvaging.net/ship/ship_main.htm

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State	Agency Name	Contact Information	Web Site
New York	New York State Office for the Aging	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251 (800) 342-9871	http://www.aging.ny.gov/
Ohio	Ohio Department of Insurance	50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215 800-686-1526	http://www.insurance.ohio.gov/Pages/default.aspx
Oklahoma	SHIP Senior Health Insurance Counseling Program	Five Corporate Plaza 3625 NW 56th, Suite 100 Oklahoma City, OK 73112-4511 800.763.2828	http://www.ok.gov/oid/Consumers/Information_for_Seniors/Senior_Health_Insurance_Counseling_Program_(SHIP)/index.html
Oregon	Senior Health Insurance Benefits Assistance Program	350 Winter Street NE, Suite 330, P.O. Box 14480 Salem, OR 97309-0405 Phone: 503-947-7979 Toll-free: 800-722-4134 Fax: 503-947-7092 TTY: 800-735-2900	http://www.oregon.gov/DCBS/SHIBA/
Pennsylvania	Apprise Health Insurance Counseling Program	Centre County Office of Aging Willowbank Office Building 420 Holmes Street Bellefonte, PA 16823-1488 800-783-7067	http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616587&mode=2
Rhode Island	Division of Elderly Affairs	74 West Road Hazard Bldg , 2nd Floor Cranston RI 02920 401-462-3000 401-462-0740	http://www.dea.ri.gov/insurance/

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
South Carolina	Office on Aging	1301 Gervais Street Suite 350 Columbia, SC 29201 Phone: (803) 734-9900 Toll Free: (800) 868-9095 Fax: (803) 734-9886 and (803) 734-9887	http://aging.sc.gov/Pages/default.aspx
South Dakota	SHIINE	Eastern South Dakota: Phone: 1-800-536-8197 or 605-333-3314 Central South Dakota: Phone: 1-877-331-4834 or 605-224-3212 Western South Dakota: Local: 1-877-286-9072 or 605-342-8635	http://www.shiine.net/
Tennessee	Tennessee's State Health Insurance Assistance Program (SHIP)	Andrew Jackson Building 500 Deaderick Street, Suite 825 Nashville, TN 37243-0860 877-801-0044 (615) 741-2056	http://www.state.tn.us/comaging/ship.html
Texas	Health Information Counseling and Advocacy Program (HICAP)	701 W. 51st St. Austin, Texas 78751 800-458-9858 800-252-9240	http://www.dads.state.tx.us/
Utah	Aging and Adult Services	195 North 1950 West Salt Lake City, UT 84116 Phone: (801) 538-3910 Toll free: 1-877-4aging0 or 1-877-424-4640 Fax: (801) 538-4395 Email: DAAS@utah.gov	http://www.hsdaas.utah.gov/insurance_programs.htm

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Virginia	Virginia Department for the Aging	Virginia Department for the Aging 1610 Forest Avenue, Suite 100 Richmond, VA 23229 1-800-552-3402 (Nationwide Voice/TTY) VA TTY Relay: 711	http://www.vda.virginia.gov/
Vermont	Vermont SHIP	Northeastern Vermont Area Agency on Aging 481 Summer Street, Suite 101 St. Johnsbury, Vermont 05819 1-802-748-5182 1-800-552-3402 (Nationwide Voice/TTY)	http://www.medicarehelpt.net/
Washington	SHIBA Health	SHIBA HelpLine Office of Insurance Commissioner PO Box 40256 Olympia, WA 98504-0256 800-562-6900 TDD: 360-586-0241	http://www.insurance.wa.gov/shiba/index.shtml
West Virginia	WV SHIP	1900 Kanawha Blvd. East Charleston, WV 25305 (304) 558-3317 (877) 987-4463 Fax: (304) 558-0004	http://www.wvship.org/
Wisconsin	State Health Insurance Assistance Program (SHIP)	1 West Wilson Street Madison, WI 53703 866-456-8211 888-758-6047 TTY/Textnet	http://www.dhs.wisconsin.gov/aging/EBS/ship.htm
Wyoming	WyomingSeniorCitizens, Inc.	P.O. Box BD Riverton, WY 82501 (307) 856-6880 (877) 634-1005 Fax: (307) 856-4466	http://www.wyomingseniors.com/WSHIIP.htm

QIO - Quality Improvement Organization (formerly PRO - Peer Review Organization)

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Alabama	Alabama Quality Assurance Foundation	Two Perimeter Park South Suite 200 West Birmingham, AL 35243-23374 (205) 970-1600 Fax: (205) 970-1616	http://www.aqaf.com/
Arkansas	Arkansas Foundation for Medical Care	1020 West 4th Street, Suite 300 Little Rock, AR 72201 Phone: (501) 212-8600 Toll Free: 1-888-987-1200	http://www.afmc.org/HTML/index/index.aspx
Arizona	Health Services Advisory Group	1600 East Northern Avenue Suite 100 Phoenix, AZ 85020 (602) 264-6382 Fax: (602) 241-0757	http://www.hsag.com/home.aspx
California	Health Services Advisory Group	700 N. Brand Blvd. Suite 410 Glendale, CA 91203 (818) 409-9229	http://www.hsag.com/home.aspx
Colorado	Colorado Foundation for Medical Care	23 Inverness Way East Suite 100 Englewood, CO 80112-5708 (303) 695-3300 Fax: (303) 695-3350	http://www.cfmc.org/
Connecticut	Qualidigm	1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067 (860) 632-6398 Fax: (860) 632-6326	http://www.qualidigm.org/
Delaware	Quality Insights of Delaware	Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810 (302) 478-3600 Fax: (302) 478-3873	http://www.qide.org/Home.aspx

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Florida	FMQAI	5201 W. Kennedy Boulevard, Suite 900 Tampa, FL 33609-1812 (813) 354-9111 Fax: (813) 354-0737	http://www.fmqai.com/
Georgia	Alliant GMCF	1455 Lincoln Parkway Suite 800 Atlanta, GA 30346 (404) 982-0411 Fax: (404) 982-7584	http://www.gmcf.org/AlliantWeb/Default.aspx
Iowa	Telligen	6000 Westown Parkway Suite 350 E West Des Moines, IA 50266-7771 (515) 223-2900 Fax: (515) 222-2407	http://www.telligen.org/
Idaho	Qualis Health	720 Park Blvd. Suite 120 Boise, ID 83712-7756 (208) 343-4617 Fax: (208) 343-4705	http://www.qualishealth.org/
Illinois	Illinois Foundation for Quality Health Care	2625 Butterfield Road Suite 102E Oak Brook, IL 60523-1234 (800) 386-6431 Fax: (630) 571-5611	http://www.ifmc-il.org/
Indiana	Health Care Excel	2629 Waterfront Parkway East Drive Suite 200 Indianapolis, IN 46214 Phone: (317) 347-4500 Fax: (317) 347-4567	http://www.hce.org/
Kansas	Kansas Foundation for Medical Care	2947 S.W. Wanamaker Drive Topeka, KS 66614-4193 (785) 273-2552 Fax: (785) 273-0737	http://www.kfmc.org/

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Kentucky	Health Care Excel	1951 Bishop Lane, Suite 300 Louisville, KY 40218 Phone: (502) 454-5112 Fax: (502) 454-5113	http://www.hce.org/
Louisiana	eQHealth Solutions	8591 United Plaza Blvd. Suite 270 Baton Rouge, LA 70809 (225) 926-6353 Fax: (225) 923-0957	http://www.lhcr.org/
Massachusetts	MassPRO	245 Winter Street Waltham, MA 02145 (781) 890-0011 Fax: (781) 487-0083	http://www.masspro.org/
Maryland	Delmarva Foundation	9240 Centreville Road Easton, MD 21601 (410) 822-0697 Fax: (410) 822-7291	http://www.mdqio.org/
Maine	Northeast Health Care Quality Foundation	15 Old Rollinsford Rd. Suite 302 Dover, NH 03820-2830 (603) 749-1641 Fax: (603) 749-1195	http://www.nhcqf.org/
Michigan	MPRO	22670 Haggerty Road, Suite 100 Farmington Hills, MI 48170-4495 (248) 465-7300 Fax: (248) 465-7428	http://www.mpro.org/
Minnesota	Stratis Health	2901 Metro Drive Suite 400 Bloomington, MN 55425 (952) 854-3306 Fax: (952) 853-8503	http://www.stratishealth.org/index.html
Missouri	Primaris	200 N. Keene St. Columbia, MO 65201 (573)-817-8300 Fax: (573) 817-8330	http://www.primaris.org/

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Mississippi	Information & Quality Health Care	Renaissance Place, Suite 504 385B Highland Colony Parkway Ridgeland, MS 39157-6035 (601) 957-1575 Fax: (601) 956-1713	http://www.iqh.org/
Montana	Mountain-Pacific Quality Health Foundation	3404 Cooney Drive Helena, MT 59602 (406) 443-4020 Fax: (406) 443-4585	http://www.mpqhf.org/
North Carolina	The Carolinas Center for Medical Excellence	100 Regency Forest Drive Suite 100 Cary, NC 27511-8598 (919) 380-9860 Fax: (919) 380-7637	http://www.thecarolinascenter.org/
North Dakota	North Dakota Health Care Review, Inc.	800 31st Avenue, SW Minot, ND 58701 (701) 852-4231 Fax: (701) 838-6009	http://www.ndhcri.org/
Nebraska	CIMRO of Nebraska	1230 O Street, Suite 120 Lincoln, NE 68508 (402) 476-1399 Fax: (402) 476-1335	http://www.cimronebraska.org/default.aspx
New Hampshire	Northeast Health Care Quality Foundation	15 Old Rollinsford Rd. Suite 302 Dover, NH 03820-2830 (603) 749-1641 Fax: (603) 749-1195	http://www.nhcqf.org/
New Jersey	Healthcare Quality Strategies, Inc.	557 Cransbury Road Suite 21 East Brunswick, NJ 08816-4026 (732) 238-5570 Fax: (732) 238-7766	http://www.pronj.org/index.html

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
New Mexico	New Mexico Medical Review Association	Seagull Office Plaza 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109 (505) 998-9898 Fax: (505) 998-9899	http://www.nmmra.org/
Nevada	HealthInsight	6830 W. Oquendo Road, Suite 102 Las Vegas, Nevada 89118 (702) 385-9933 Fax: (702) 385-4586	http://www.healthinsight.org/
New York	IPRO	1979 Marcus Avenue First Floor Lake Success, NY 11042 (516) 326-7767 Fax: (516) 326-7791	http://www.ipro.org/
Ohio	Ohio KePRO	Rock Run Center Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 (216) 447-9604 Fax: (216) 447-7925	http://www.ohiokepro.com/
Oklahoma	Oklahoma Foundation for Medical Quality	14000 Quail Springs Parkway, Ste. 400 Oklahoma City, OK 73134-2600 (405) 840-2891 Fax: (405) 840-1343	http://www.ofmq.com/
Oregon	Acumentra Health	2020 SW 4th Avenue Suite 520 Portland, OR 97201-4960 (503) 279-0100 Fax: (503) 279-0190	http://www.acumentra.org/
Pennsylvania	Quality Insights of Pennsylvania	Commerce Court 2601 Market Place Street Harrisburg, PA 17111 717-671-5425	http://www.qipa.org/Home.aspx

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Rhode Island	Quality Partners of Rhode Island	235 Promenade Street Suite 500, Box 18 Providence, RI 08908 (401) 528-3200 Fax: (401) 528-3210	http://www.healthcentricadvisors.org/home.html
South Carolina	The Carolinas Center for Medical Excellence	246 Stoneridge Drive, Suite 200 Columbia, SC 29210 (803) 251-2215 Fax: (803) 255-0897	http://www.thecarolinascenter.org/
South Dakota	South Dakota Foundation for Medical Care	1323 South Minnesota Avenue Sioux Falls, SD 57105-0691 (605) 336-3505 Fax: (605) 336-0270	http://www.sdfmc.org/
Tennessee	Qsource	3175 Lenox Park Blvd. Suite 309 Memphis, TN 38115 (901) 682-0381 Fax: (901) 761-3786	http://www.qsource.org/
Texas	TMF Health Quality Institute	Bridgepoint I, Suite 300 5918 W Courtyard Dr. Austin, TX 78730-5036 512-329-6610 fax: 512-327-7159	http://www.tmf.org/
Utah	HealthInsight	348 East 4500 South Suite 300, Salt Lake City, Utah 84107 (801) 892-0155 Fax: (801) 892-0160	http://www.healthinsight.org/
Virginia	Virginia Health Quality Center	4510 Cox Road Suite 400 Glen Allen, VA 23060 (804) 289-5320 Fax: (804) 289-5324	http://www.vhqc.org/

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Vermont	Northeast Health Care Quality Foundation	15 Old Rollinsford Rd. Suite 302 Dover, NH 03820-2830 (603) 749-1641 Fax: (603) 749-1195	http://www.nhcqf.org/
Washington	Qualis Health	10700 Meridan Avenue, North Suite 100 Seattle, WA 98133-9075 (206) 364-9700 Fax: (206) 368-2419	http://www.qualishealth.org/
West Virginia	West Virginia Medical Institute	3001 Chesterfield Place Charleston, WV 25304 (304) 346-9864 Fax: (304) 346-9863	http://www.wvmi.org/Home.aspx
Wisconsin	MetaStar, Inc.	2909 Landmark Place Madison, WI 53713 (608) 274-1940 Fax: (608) 274-5008	http://www.metastar.com/web/
Wyoming	Mountain-Pacific Quality Health Foundation	2206 Dell Range Blvd., Suite G Cheyenne, WY 82009 307-637-8162 Fax: 307-436-7176	http://www.mpqhf.org/

State Medical Assistance Office (Medicaid)

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Alabama	Alabama Medicaid Agency	501 Dexter Avenue Montgomery, AL 36104 334-242-5000 800-362-1504	http://medicaid.alabama.gov/
Arkansas	Arkansas Medicaid	(800) 457-4454 (501) 374-6609 x 500 Voice Response System (VRS) (800) 806-6181	https://www.medicaid.state.ar.us/
Arizona	AHCCCS	801 E. Jefferson Street, MD 4100 Phoenix, AZ 85034 Ph: 602-417-4000 FAX: 602-252-6536 800-654-8713	http://www.azahcccs.gov/
California	Medi-Cal	800-541-5555 916-445-4171	http://www.medi-cal.ca.gov/
Colorado	Department of Health Care Policy and Financing	1570 Grant Street Denver, Colorado 80203 303-866-3513 1-800-221-3943 TDD 1-800-659-2656	http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675
Connecticut	Connecticut Department of Social Services	25 Sigourney Street Hartford, CT 06106 1-800-842-1508 TTY: 1-800-842-4524	http://www.ct.gov/dss/cwp/view.asp?a=2353&q=305218
Delaware	Medicaid	1901 N. Du Pont Highway, Lewis Bldg. New Castle, DE 19720 (302) 255-9500 FAX: (302) 255-4454	http://www.dhss.delaware.gov/dss/medicaid.html
Florida	Florida Medicaid	2727 Mahan Drive Tallahassee, FL 32308 (888) 419-3456	http://www.fdhc.state.fl.us/Medicaid/index.shtml

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Georgia	Georgia Department of Community Health (DCH)	2 Peachtree Street, NW Atlanta, GA 30303 (404) 656-4507 1.800.georgia	http://dch.georgia.gov/02/dch/home/0,2467,31446711,00.html;jsessionid=C453CE0C0F3B88EF349740CB01B15ED6
Iowa	Iowa Department of Human Services	Polk County DHS - Administrative Offices River Place 2309 Euclid Ave Des Moines, IA 50310 877-937-3663	http://www.dhs.iowa.gov/Consumers/Health/Medical_Insurance/WhatsAvailable.html
Idaho	Department of Health and Welfare	Idaho Department of Health and Welfare PO Box 83720 Boise, ID 83720-0036 208-334-6700	http://healthandwelfare.idaho.gov/
Illinois	Illinois Department of Healthcare and Family Services (HFS)	1-866-468-7543 1-217-785-8036 TTY: 1-877-204-1012	http://www.hfs.illinois.gov/programs/
Indiana	Indiana Medicaid	(317) 713-9627 (800) 457-4584	http://member.indianamedicaid.com/
Kansas	Kansas Medical Assistance Program	(888) 547-2878	https://www.kmap-state-ks.us/
Kentucky	Department for Medicaid Services	275 E. Main St. Frankfort, KY 40621 1-800-372-2973 TTY: 1-800-627-4702	http://chfs.ky.gov/dms/
Louisiana	Louisiana Medicaid	P. O. Box 629 Baton Rouge, LA 70821-0629 1.888.342.6207 225.342.9500 FAX: 225.342.5568	http://new.dhh.louisiana.gov/index.cfm/subhome/1
Massachusetts	MassHealth	1-888-665-9993 TTY: 1-888-665-9997	http://www.mass.gov/?pageID=eohhs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Maryland	Medicaid	(410) 767-1787 (800) 492-5231	http://www.dhmh.state.md.us/mma/Eligibility/MAelig-2009Q&A.html
Maine	MaineCare Services	Office of MaineCare Services 11 State House Station, Augusta, Maine 04333-0011 1-800-977-6740 TTY:1-800-977-6741	http://www.maine.gov/dhhs/oms/
Michigan	Department of Community Health	Capitol View Building 201 Townsend Street Lansing, Michigan 48913 517-373-3740 TTY: 711 or 800-649-3777	http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html
Minnesota	Minnesota Department of Human Services	MinnesotaCare PO Box 64838 St. Paul, MN 55164-0838 (651) 297-3862 in the Twin Cities metro area (800) 657-3672 toll free from outside the Twin Cities TTY: (800) 627-3529 or 711	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_006254
Missouri	MO HealthNet	615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 (573) 751-3425	http://www.dss.mo.gov/fsd/msmed.htm
Mississippi	Division of Medicaid	Sillers Building, 550 High Street Suite 1000 Jackson, MS 39201-1399 601-359-6050 1-800-421-2408	http://www.medicaid.ms.gov/
Montana	Montana Medicaid	(800) 362-8312	http://www.dphhs.mt.gov/programsservices/medicaid.shtml

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
North Carolina	Division of Medical Assistance	2501 Mail Service Center Raleigh, NC 27699-2501 800-662-7030	http://www.ncdhhs.gov/dma/
North Dakota	North Dakota Medicaid	North Dakota Department of Human Services 600 E Boulevard Ave, Dept 325 Bismarck, ND 58505-0250 (701) 328-2321 Toll-free: 1-800-755-2604 Fax: (701) 328-1544	http://www.nd.gov/dhs/services/medicalserv/medicaid/
Nebraska	Nebraska Medicaid Program	301 Centennial Mall South Lincoln, Nebraska 68509 (402) 471-3121	http://www.hhs.state.ne.us/med/medindex.htm
New Hampshire	Medicaid	40 Terrill Park Drive Concord, NH 03301 (603) 271-4344 (800) 322-9191 TDD Access Relay: (800) 735-2964	http://www.dhhs.nh.gov/ombp/medicaid/
New Jersey	NJ Medicaid & Managed Care	P. O. Box 360, Trenton, NJ 08625-0360 Phone: (609) 292-7837 Toll-free in NJ: 800-367-6543	http://www.state.nj.us/humanservices/dmahs/info/resources/care/
New Mexico	Medical Assistance Division	2009 S. Pacheco, Pollon Plaza Santa Fe, NM 87504 (888) 997-2583	http://www.hsd.state.nm.us/mad/
Nevada	Division of Health Care Financing and Policy	Carson City 1100 East William Street Suite 101 Carson City, NV 89701 (775) 684-3676	https://dhcfnv.gov/index.htm
New York	Medicaid	1-800-541-2831	http://www.health.ny.gov/health_care/medicaid/

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Ohio	Ohio Medicaid	The Ohio Department of Job and Family Services 30 E. Broad Street, 32nd Floor Columbus, Ohio 43215 (800) 324-8680 TTY/TDD (800) 292-3572	http://jfs.ohio.gov/ohp/
Oklahoma	Oklahoma Health Care Authority	2401 N.W. 23rd St., Suite 1A Oklahoma City, OK 73107 (800) 987-7767 (800) 757-5979 (TDD)	http://www.okhca.org/
Oregon	Oregon's Medicaid State Plan	Division of Medical Assistance Programs Administrative Office 500 Summer Street NE Salem, OR 97301-1079 Phone: 503-945-5772 Phone: 800-527-5772 TTY: 800-375-2863	<a href="http://www.oregon.gov/OH
A/healthplan/tools_policy/
stateplan.shtml">http://www.oregon.gov/OH A/healthplan/tools_policy/ stateplan.shtml
Pennsylvania	Medical Assistance	1-800-692-7462	<a href="http://www.dpw.state.pa.u
s/foradults/healthcaremedi
calassistance/index.htm">http://www.dpw.state.pa.u s/foradults/healthcaremedi calassistance/index.htm
Rhode Island	RI Medical Assistance	206 Elmwood Avenue Providence, RI 02907 (401) 462-5300	<a href="http://www.dhs.ri.gov/Adu
lts/HealthMedicalServices/
tabid/807/Default.aspx">http://www.dhs.ri.gov/Adu lts/HealthMedicalServices/ tabid/807/Default.aspx
South Carolina	South Carolina Healthy Connections (Medicaid) Program	Post Office Box 100101 Columbia, South Carolina 29202-3101 888-549-0820	<a href="http://www.dhhs.state.sc.u
s/dhhsnew/InsideDHHS/B
ureaus/EligibilityPolicyAnd
Oversight/Partners%20for
%20Health%20(Medicaid)
%20Program.asp">http://www.dhhs.state.sc.u s/dhhsnew/InsideDHHS/B ureaus/EligibilityPolicyAnd Oversight/Partners%20for %20Health%20(Medicaid) %20Program.asp
South Dakota	Division of Medical Services	Phone: 605-773-4678 Fax: 605-773-7183	<a href="http://dss.sd.gov/medicalse
rvices/">http://dss.sd.gov/medicalse rvices/
Tennessee	TennCare	310 Great Circle Rd. Nashville, TN 37243 1-800-342-3145	<a href="http://www.state.tn.us/tenn
care/">http://www.state.tn.us/tenn care/

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Texas	Texas Medicaid Program	P.O. Box 14200 Midland, TX 79711-4200 1-800-252-8263	http://www.hhsc.state.tx.us/medicaid/
Utah	Utah Medicaid Program	Utah Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 801-538-6155 1-800-662-9651	http://health.utah.gov/medicaid/
Virginia	Virginia Medicaid	800-552-8627 804-786-6273	https://www.viriniamedicaid.dmas.virginia.gov/wps/portal
Vermont	Green Mountain Care	1-800-250-8427 TDD: 1-888-834-7898	http://www.greenmountaincare.org/
Washington	Health Care Authority	800-562-3022	http://maa.dshs.wa.gov/
West Virginia	Bureau for Medical Services	(304) 558-1700	http://www.dhhr.wv.gov/bms/Pages/default.aspx
Wisconsin	ForwardHealth: Wisconsin Medicaid	1-800-362-3002	http://www.dhs.wisconsin.gov/medicaid/
Wyoming	EqualityCare	6101 Yellowstone Rd., Ste 210 Cheyenne, WY 82002 (307) 777-7531	http://wyequalitycare.acs-inc.com/

State Health Departments

State Health Departments		
State	Agency Name	Contact Information
Alabama	Alabama Department of Public Health	1-800-ALA-1818
Arkansas	Arkansas Department of Health	1-501-661-2000 1-800-462-0599
Arizona	Arizona Department of Health Services	(602) 542-1025
California	Department of Health Care Services (DHCS)	916-445-4171
Colorado	Colorado Department of Public Health and Environment	303- 692-2000 1-800-886-7689
Connecticut	Department of Public Health	860-509-8000
Delaware	Delaware Health and Social Services	(302) 744-4700
Florida	Florida Department of Health	850/245-4444
Georgia	Georgia Department of Public Health (DPH)	(404) 657-2700
Iowa	Iowa Department of Public Health	866-227-9878
Idaho	Idaho Department of Health and Welfare	(208) 334-6996
Illinois	Illinois Department of Public Health	217-782-4977 TTY 800-547-0466
Indiana	Indiana State Department of Health	(317) 233-1325
Kansas	Kansas Department of Health and Environment	785-296-1500
Kentucky	Department for Public Health	800-372-2973
Louisiana	Office of Public Health	(225) 342-9500
Massachusetts	Department of Public Health	617-573-1600
Maryland	Department of Health and Mental Hygiene	1-877-463-3464
Maine	Department of Health and Human Services	207-287-3707 TTY: 800-606-0215
Michigan	Michigan Department of Community Health	517-373-3740
Minnesota	Minnesota Department of Health	888-345-0823 TTY: 651-201-5797
Missouri	Missouri Department of Health and Senior Services	573-751-6400

State Health Departments		
State	Agency Name	Contact Information
Mississippi	Mississippi State Department of Health	601-576-7400
Montana	Department of Public Health & Human Services	(406) 444-0936
North Carolina	Division of Public Health	919-707-5000
North Dakota	North Dakota Department of Health	701.328.2372
Nebraska	Department of Health and Human Services	402-471-3121
New Hampshire	Department of Health and Human Services	(603) 271-4501
New Jersey	Department of Health and Senior Services	1-800-328-3838
New Mexico	Department of Health	(505) 827-2613
Nevada	Nevada State Health Division	(775) 684-4200
New York	Department of Health	1-866-881-2809
Ohio	Ohio Department of Health	(800) 755-4769
Oklahoma	State Department Of Health	800-522-0203 405-271-5600
Oregon	Public Health Division	971-673-1222
Pennsylvania	Department Of Health	877-PA-HEALTH
Rhode Island	Department of Health	401-222-5960
South Carolina	Department of Health and Human Services	(888) 549-0820
South Dakota	Department of Health	800-738-3361
Tennessee	Department of Health	(615) 741-3111
Texas	Texas Department of State Health Services	1-888-963-7111 TDD: 1-800-735-2989
Utah	Department of Health	801-538-6003
Virginia	Department of Health	(804) 864-7660
Vermont	Department of Health	800-464-4343
Washington	Department of Health	(800) 525-0127
West Virginia	Department of Health and Human Resources	(304) 558-0684
Wisconsin	Department of Health Services	608-266-1865
Wyoming	Department of Health	(866) 571-0944

Appendix B - Service Area and Premium Table

Today's Options Advantage 400 (PPO)

Today's Options Advantage 400 (PPO)		
State	County	Premium
Maine	Androscoggin	\$10
Maine	Penobscot	\$10
New York	Clinton	\$45
Pennsylvania	Bucks	\$10
Pennsylvania	Crawford	\$45
Pennsylvania	Erie	\$10
Pennsylvania	Luzerne	\$10
Pennsylvania	Montgomery	\$45
Pennsylvania	Northumberland	\$10
Virginia	Henrico	\$10
Virginia	Richmond City	\$10

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Today's Options[®] PPO

Medicare Advantage Health Plans

Member Services

CALL	(866) 422-5009 Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	(877) 907-2985 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 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(877) 907-2982
WRITE	Today's Options PPO P.O. Box 742528 Houston, TX 77274
WEBSITE	www.TodaysOptionsPPO.com

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Please see the listing provided in Appendix A at the end of the *Evidence of Coverage* for contact information.

Today's Options[®] PPO is offered by the following organization that contracts with the Federal government: American Progressive Life & Health Insurance Company of New York, a member of the Universal American family of companies.

Medicare-approved PPO plan.

This information is available in a different format, including in Spanish. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información está disponible en diferentes formatos, incluyendo el español. Por favor llame a Servicios al Cliente al número indicado arriba si necesita información del plan en otro formato u idioma.

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