TheHealthPlan

Chapter 7

Medicare Advantage (MA)

SecureCare HMO Medicare Advantage Plan

The Health Plan (THP) entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to THP for each Medicare beneficiary who enrolls in a THP plan. This contract requires THP to provide comprehensive health services to persons who are entitled to Medicare benefits and choose to enroll in THP. THP receives a set rate for each member plus any member premium. The benefits for SecureCare Health Maintenance Organization (HMO) members are identical to traditional Medicare benefits along with additional enhanced benefits.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

THP Customer Service Department is available to assist with questions and can be reached at 1.877.847.7907.

Sample SecureCare HMO Medicare Advantage Member ID Card

THP Medicare Advantage member ID cards are color-coded orange to more easily identify THP's Medicare Advantage population.

FRONT

BACK

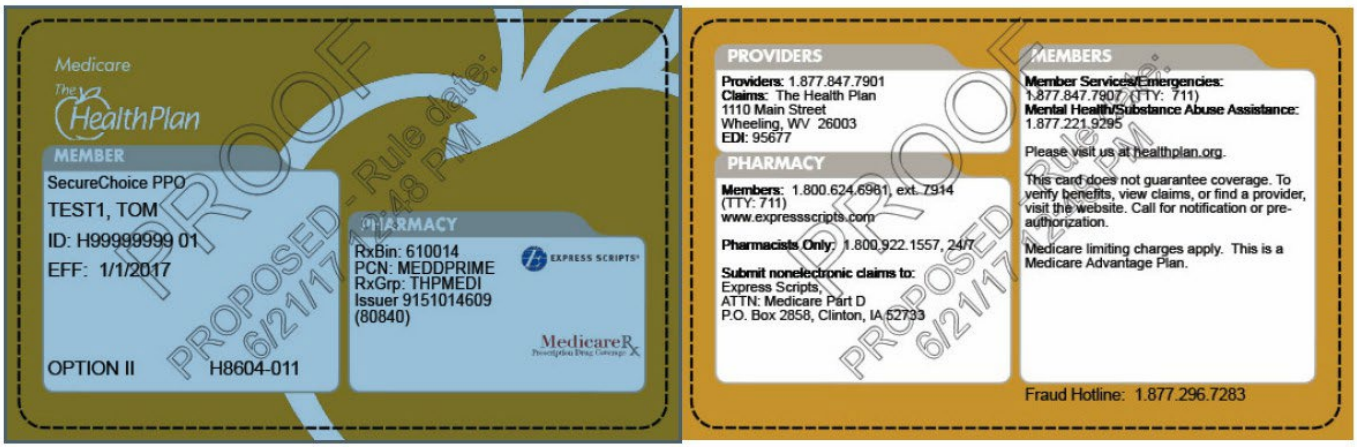
SecureChoice PPO Medicare Advantage Plan

SecureChoice Preferred Practitioner Organization (PPO) is THP's Medicare Advantage preferred practitioner organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. THP prior authorization requirements apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from THP's extensive network of participating practitioners. The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare practitioner of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits and THP offers enhanced benefits for SecureChoice members. As with the SecureCare HMO plan, it is imperative that you are aware of these rights and responsibilities as a participating practitioner so that you may assist our members within your practice.

Sample SecureChoice PPO Medicare Advantage Member ID Card



Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

Effective January 1, 2014, THP began a Coordination Only (CO) Medicare Advantage (MA) Dual-Eligible Special Needs Plan (D-SNP) for populations that are dually eligible for both Medicare and Medicaid coverage. D-SNP members are individuals with both Medicare Part A and Part B coverage who also meet the Medicaid eligibility requirements of their state of residence.

Every SNP is required to have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The NCQA MOC approval process follows standards and scoring guidelines established by Centers for Medicare and Medicaid Services (CMS). THP received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan, which also applies to THP's D-SNP program.

THP's MOC is a written document describing the fundamental framework and measurable goals of the program. THP's MOC implements a comprehensive approach to managing and coordinating care to enhance access to medically necessary care, improve quality of care and ensure continuity of needed services. The care management team uses a Health Risk Assessment Tool (HRAT) designed to assess information collected from the member about their self-perceived health status and develop an individualized plan of care (ICP). As mandated by CMS, THP provides initial and annual MOC training to personnel and practitioners (network and out-of-network) about the program to ensure integrated coordination of care for the D-SNP population.

D-SNP Measurable goals

The following list includes examples of THP's measurable goals for the D-SNP:

- Improve access to essential services including medical, behavioral health, and social services by providing a comprehensive network. Every D-SNP member will be assigned a case manager with licensed social workers readily available.
- Require D-SNP members to select a primary care practitioner (PCP) and assign a THP case manager to the member.
- Streamline the process of transition of care across health care settings, practitioners, and health services coordinated by the practitioner and the care manager.
- Improve access to preventive care.
- Improve member health outcomes through annual Healthcare Effectiveness Data and Information Set (HEDIS®) data collection and member surveys.

D-SNP Practitioner Reimbursement and Billing

The practitioner will bill THP for medically appropriate covered services provided to the D-SNP member. THP will reimburse the practitioner for services rendered, according to the member's benefit plan, less any copays, coinsurance, or deductible amounts. The practitioner will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to the West Virginia or Ohio Medicaid program. THP accepts full and partial D-SNP members. Members who have partial status may have limited coverage from their state plan.

Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by THP on the date indicated in the notification.

Federal law prohibits Medicare practitioners from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare practitioners must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Practitioners who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the act is available on the Social Security Administration's website: ssa.gov "Compilation of the Social Security Laws."

Practitioners may not discriminate by refusing to serve members because they receive assistance with Medicare cost-sharing from a state Medicaid program.

D-SNP Practitioner education

Each calendar year, all Medicare Advantage participating practitioners must complete and attest to D-SNP MOC training. THP conducts D-SNP practitioner education through several approaches including face-to-face or web-based training and email broadcasts.

THP's D-SNP MOC Annual Training and attestation are located on THP's secure practitioner portal.

If training is not complete and attested to each calendar year, THP may issue the practitioner a documented corrective action plan (CAP).

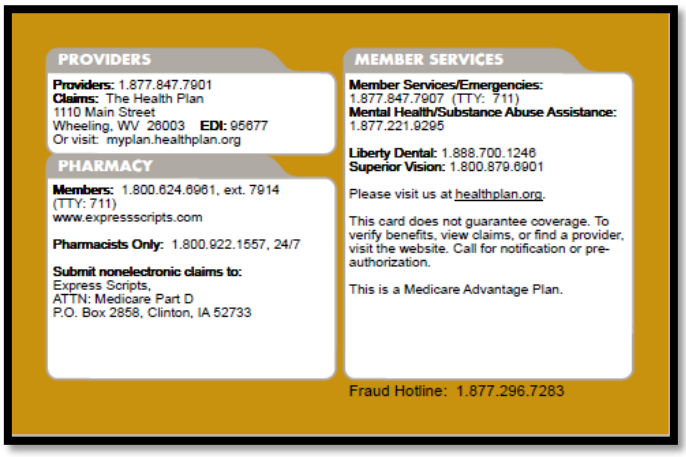
Each CAP will include a sixty (60) day cure period. During the sixty (60) day cure period, THP will:

1. Stop D-SNP member auto-assignment to network practitioners with incomplete D-SNP MOC training.

2. Suspend Alternative Payment Model Category 2 care coordination fees for assigned members, as applicable.

If the CAP is cured, THP will re-start member auto-assignment and re-institute care coordination fees, as applicable. If the CAP is not cured, THP will evaluate network practitioners for removal from the network.

Sample Medicare Advantage Dual Eligible Special Needs (D-SNP) Member ID Card



Vision Service Benefit

Members enrolled through THP Medicare Advantage program have vision benefits. Superior Vision administers routine vision benefits for Medicare Advantage members. Please visit superior vision at superiorvision.com or call 877.235.5317 Monday – Friday 8 a.m. to 9 p.m. EST and Saturday 11 a.m. to 4:30 p.m. EST for information on benefits and coverage under these vision plans.

Practitioners must be credentialed with Superior Vision before offering covered vision services to THP members.

Members may require ophthalmologic medical services in conjunction with a medical condition. These medical services must be offered through a contracted ophthalmologist or optometrist with THP. A referral from the primary care practitioner (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Billing Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered and not separately reimbursed as it is a component part of an eye exam.

Billing Procedures

The visit is billed to THP with the following codes:

92002, 92004, 92012, or 92014	**Eye exam, new or established patient**
92015	**Determination of refractive state**

Medicare Advantage Coordination of Benefits (COB)

Medicare Advantage is not always the primary payer for health insurance claims. THP will comply with the Centers for Medicare and Medicaid Services' (CMS) requirement to provide information pertaining to claims in which Medicare Advantage is secondary. Medicare Advantage is the secondary payer when the beneficiary is entitled to:

- Veteran's Benefits
- Workers' Compensation
- Black Lung Benefits
- Employer Group coverage based on the Medicare secondary payer guidelines.

THP Insurance Company Medicare Supplemental Plans

Original Medicare beneficiaries who have Original Medicare as their primary insurance can select a THP Medicare Supplement Plan and pay a monthly premium to THP to cover their Medicare deductibles and coinsurance. These plans do not require a member to choose a primary care practitioner (PCP) or obtain a referral for specialty physician services.

Medicare Non-Covered Service Guidelines

THP Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require THP to provide appropriate notice of non-coverage/coverage to the members and educate practitioners on 1) coverage and exclusions of medical services; 2) limits of plan coverage; and 3) how to correctly advise members prior to providing services of such limitations or service exclusion under Medicare. To ensure that practitioners understand the member's role and responsibility regarding covered and non-covered medical services, THP provides this training information as a guide.

Providing Notice of Non-Coverage

The first method THP utilizes to educate members of non-covered services is provided upon enrollment, through the Evidence of Coverage (EOC) booklet Chapter "What services are not covered by the plan?"

The second method is provided through the "Notice of Denial (or partial denial) of Medical Coverage" issued through prior authorization, coverage determination, or organization determination) process.

For every service billed to THP, the member receives an Explanation of Benefits (EOB) that provides an explanation of the charges and what, if any, the member is financially responsible for paying to the practitioner.

Unsure if Covered

For a service or item that is typically not covered but could be covered under specific conditions i.e., dental care that is necessary to treat an illness or injury, the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member financial liability. In such instances, the appropriate process is for the member, or the practitioner acting on behalf of the member, to request a pre-service determination.

Never Covered

If a service is never covered by THP (statutorily excluded from coverage per Medicare rules) and THP's EOC provided to the member is clear that the service or item is never covered, THP is not required to hold the member harmless from the full cost of the service or item.

Appeal Rights

For any payment or coverage request for service that THP receives and denies, a standardized denial notice, as stated above, is provided with appeal rights. The member, or treating practitioner, has the right to appeal any denial of a service or item. THP will not take punitive action against practitioners who request an expedited resolution or support a member's appeal.

Member Liability

When the practitioner or THP acting on behalf of the practitioner, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that:

a) The item or service is not covered by THP; or

b) That coverage is available only if the member is referred for the service by a contracted practitioner and nonetheless, the member receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require that plans hold the member harmless from the full cost of the service or item charged by the practitioner.

Medicare Advantage Billing Rules

This section explains how and when to bill a member for non-covered services.

As a contracted practitioner with THP, you must always submit a claim for payment of services to THP prior to billing our members, even if you have received a pre-service determination denial.

Billing for Non-covered Services

GY - No pre-service determination was made

Practitioners should append this modifier when you informed/explained to the member that their THP EOC includes a "clear" exclusion, and the service was not covered.

GA - Pre-service notice of non-coverage was provided by THP

Practitioners should append this modifier when:

- A pre-service determination was requested and the "Notice of Denial (or partial denial) of Medical Coverage" was issued; or
- The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service

Note: When using the GA modifier please provide the pre-service determination number on the claim

When practitioners bill with these modifiers, the claims are processed with the appropriate codes for member financial liability, and you may bill the member. If you bill for non-covered services without using the GA or GY modifier, THP will deny your claim as practitioner responsibility. If you bill THP for covered services with the GY or GA modifier, THP will deny the claim for incorrect use of modifier. Part of your responsibility as a participating practitioner is to inform your members when a service is not covered (or statutorily excluded) by THP.

Improper Use of Advance Notices of Non-Coverage (ABN)

On May 5, 2014, CMS released a memo titled "Improper Use of Advance Notices of Non-coverage", directing all Medicare Advantage organizations (MAO) and their contracted practitioners to cease with using ABN notices and ABN-like notices as they are not compliant with the Medicare Advantage organization determination requirements. Per CMS, an ABN does not apply in or under the Medicare Advantage context because a MAO member has the right under these statutes and regulations to a pre-service determination prior to receiving services.

For information on this topic, see CMS' Claims Processing Manual Chapter 1 and MLN Booklet available on CMS' website cms.gov.

Quality Measures and Standards

CMS implements quality initiatives to ensure quality health care for Medicare beneficiaries through accountability and public disclosure.

CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting. Please visit **Chapter 11 - Quality** for additional information.

Quality measures are tools that help measure or quantify healthcare processes, outcomes, member perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, member-centered, equitable, and timely care.

Member Incentives

THP encourages its members to participate in preventive care screenings. Medicare Advantage HMO and PPO members may qualify for incentives by completing select health activities. Eligible members will receive their reward to their InComm Card after THP receives the claim for services rendered.

THP's member incentives include:

- Medicare Annual Wellness Visits - $25
  - Eligible screening codes for Medicare Annual Wellness Visit:
    - G0402 – Initial Preventive Physical Exam
    - G0438 – Initial Annual Wellness Visit
    - G0439 – Subsequent Annual Wellness Visit
    - G0468 – Federally Qualified Health Center (FQHC)Annual Wellness Visit

For additional information on Annual Wellness Visits and requirements, visit https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits.

- Colorectal Cancer Screening - $25
- Breast Cancer Screening - $25

Appointment of Representative Statement for a Medicare Member

To appoint a representative, a Medicare member should complete the form entitled: Appointment of Representative -CMS-1696 – PDF at https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms012207. Appointment of Representative Forms are available in English, Spanish, and Large Print.

If the member does not use form CMS-1696, the member's appointment must:

- Be in writing and signed and dated by the member and their representative.
- Provide a statement appointing the representative to act on the members' behalf.
- Authorize the release of the member's personal health information to their representative.
- Include a written explanation of the purpose and scope of the representation.
- List the member and representative's names, phone numbers, and addresses.
- Include the member Medicare Number (Health Insurance Claim Number or Medicare Beneficiary Identifier)
- Indicate the member's representative's professional status, if any, or relationship to the member; and
- Be filed with the entity processing the appeal.

Unless revoked, an appointment is considered valid for one (1) year from the date the form is signed. Once the form is filed, it is valid for the duration of the appeal. Therefore, a signed form can be used for more than one appeal if the appeal is filed within one year of the date on the form.

In addition, there are certain individuals who can bring an appeal on the member's behalf, pursuant to State or other applicable laws. Such an individual, known as an "authorized representative," may be a court-appointed guardian, an individual who has durable power of attorney, a health care proxy, or a person designated under a state's health care consent statute.

Notice of Medicare Non-Coverage (NOMNC)

When to Deliver the NOMNC

A Medicare practitioner, or THP, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to members (or the beneficiary's appointed or authorized representative) for members receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two (2) calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Practitioner Delivery of the NOMNC

Practitioners must deliver the NOMNC to all members eligible for the expedited determination process per section §260 of Chapter 30 of the Medicare Claim Processing Manual (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c30.pdf) or Section 100.2 in the Part C & D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance Section of the Medicare Managed Care Manual (https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.)

A NOMNC must be delivered even if the member agrees with the termination of services. Medicare practitioners are responsible for the delivery of the NOMNC. Practitioners may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all requirements of valid notice delivery apply to designated agents.

The practitioner must ensure that the member or representative signs and dates the NOMNC to demonstrate that the member or representative received the notice and understands that the termination decision may be disputed. Use of assistive devices may be used to obtain a signature.

Instructions and CMS Forms are available on the CMS website at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

Medicare Outpatient Observation Notice (MOON)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires hospitals and critical access hospitals (CAHs) to provide written and oral notification to Medicare members receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the member is receiving observation services and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The Medicare Outpatient Observation Notice (MOON) was developed by CMS to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare members, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice no later than thirty-six (36) hours after observation services are initiated, or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the member or a person acting on behalf of the member ("representative") to acknowledge receipt of the notification. If the member or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

THP monitors hospitals and critical care hospitals annually for MOON compliance.

Medicare Appeals Overview

When a member requests coverage for a particular service, the decision on whether to provide such coverage is considered an "Organization Determination." Members have the right within 65 days of a denial to request either a standard pre-service (30-day), a post service claim (60-day) or an expedited (72 hours) reconsideration whenever THP denied a member's request for services. Part B drugs will have a standard turn-around time of seven (7) days effective January 1, 2020.

Where THP affirms its advice "Organization Determination" in whole or in part, THP must automatically forward the case file to CMS's independent review entity so that it may make a final reconsidered determination. CMS contracts with MAXIMUS Federal Service, Inc.

The parties to an organization determination for purposes of an appeal include:

- The member (including their representative)
- An assignee of the member (i.e., a practitioner who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service
- The legal representative of a deceased member's estate; or
- Any other practitioner or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Who may request reconsideration (Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance – 50.1):

1. A member, a member's representative or a non-participating practitioner to THP may request that the determination be reconsidered; however, participating practitioners do not have appeal rights. A member, a member's representative, or practitioner (regardless of whether the practitioner is affiliated with THP) are the only parties who may request that THP expedite a reconsideration.

For standard pre-service reconsiderations, a practitioner who is providing treatment to a member may, upon providing notice to the member, request a standard reconsideration on the member's behalf without submitting a representative form.

If the reconsideration request comes from the member's primary care practitioner in THP's network, no member notice verification is required.

If the request comes from either a participating or non-participating practitioner, and the member's record indicates they visited this practitioner at least once before, THP may assume the practitioner has informed the member about the request and no further verification is needed.

If this appears to be the first contact between the practitioner requesting the reconsideration and the member, THP is to undertake reasonable efforts to confirm the practitioner has given the member appropriate notice. For example:

- If the practitioner makes the request by phone, during the call, a health plan may confirm the practitioner gave the member notice that they are acting on the member's behalf.
- The practitioner makes the request by a fax, letter, or email, and copies the member on the correspondence, and/or the writing includes a statement affirming that the member knows that the physician is acting on the member's behalf with the member's knowledge and approval.

- THP may call the member and ask if they know the practitioner making the request is acting on their behalf with their knowledge and approval.

An Important Message from CMS about Member's Rights (Form CMS-R-193)

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan members) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A detailed notice of discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge.

Forms and instructions can be found on the CMS website at CMS.gov.

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or THP that inpatient care is no longer medically necessary must request an immediate review by the peer review organization (PRO) of the determination. The member must request the immediate PRO review by noon of the first working day after receipt of the notice. The member will not be financially responsible for the hospital care until the PRO makes its decision. If the admission was not authorized by THP or the admission did not constitute emergency or urgently needed care and the PRO upholds THP's determination, the member is financially responsible for the hospital costs.

A member who fails to request an immediate PRO review may request expedited reconsideration by THP through the appeal process.

Request forms and instructions can be found on the CMS website at CMS.gov.

Low Income Medicare Beneficiaries

The qualified Medicare beneficiary (QMB) program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare practitioners from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB program, including those enrolled in Medicare Advantage and other Part C Plans.

The member should make the practitioner aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. A member should not get a bill for covered medical services.

Medicare Practitioner Rights and Responsibilities

Overview of Practitioner Responsibilities

Primary Care Practitioners (PCPs):

- Act as a health care manager for members to arrange and coordinate their medical care, including but not limited to, routine care, and follow-up care after the receipt of emergency services.

Specialists:

- Provide continuity and coordination of care by sending a written report to PCPs regarding any treatment or consultation provided to members, regardless of whether the service was a result of a PCP referral or the member making his/her own arrangements.

All Contracted Practitioners Must

- Arrange for the provision of medical services to THP's members by a participating practitioner after hours, on weekends, vacations, and holidays. Services from non-participating covering practitioners may not be covered, unless otherwise approved by THP.
- Have 24-hour on-call capability, either directly or through an answering service, not an answering machine.
- Help members obtain their benefit coverage by getting written prior authorization for services that require it and prior to referring for out-of-plan services, as appropriate.
- Facilitate candid discussion with members regarding appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Such discussion should include complete and current information concerning a diagnosis, treatment, and prognosis, in terms that the member (or designee) can be expected to understand.
- Provide members the information necessary to give informed consent prior to the start of any procedure or treatment.
- Maintain appropriate medical records regarding members and their treatment, recognizing that said records are confidential and ensuring that they are maintained in accordance with legal and ethical requirements concerning confidentiality and security.
- Cooperate with THP, or its designee, in the resolution of members' complaints, expedited appeals, appeals and/or grievances.
- Comply with other administrative requirements as specified in the applicable contract or stipulated in this Manual or its updates.
- Promote the efficient delivery of medical services to maximize health care resources and the member's premium dollar and improve quality of care provided.
- Refrain from providing treatment to the practitioner's own family members.
- Provide medical information in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

NCQA Requirements:

- Comply with THP medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.

CMS Marketing Guidelines:

- Comply with CMS Marketing Guidelines (available online at https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuidelines) for practitioner-based activities. The guidelines govern how practitioners can and cannot inform or educate members about enrollment and plan information.

SecureCare/SecureChoice Member Rights and Responsibilities

An excerpt from THP's Medicare Member Handbook

Our plan must honor your rights as a member of the plan.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To receive information from us in a way that works for you, please call Customer Services at 1.877.847.7907.

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1.877.847.7907 or contact our Director of Medicare.

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 THP Appeals Coordinator at 1.877.847.7907 (TTY: 711). 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. Contact information is included in the Evidence of Coverage, or you may contact Member Services for additional information.

Visit healthplan.org to access the full Member Rights and Responsibilities.