First Choice VIP Care Plus, Medicare-Medicaid Plan: Summary of Benefits 2025

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Introduction

This document is a brief summary of the benefits and services covered by First Choice VIP Care Plus (Medicare-Medicaid Plan). It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of First Choice VIP Care Plus. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Disclaimers

This is a summary of health services covered by First Choice VIP Care Plus for 2025. This is only a summary. Please read the *Member Handbook* for the full list of benefits. To get a copy of the *Member Handbook*, call Member Services at the number at the bottom of the page. You can also find the *Member Handbook* at www.firstchoicevipcareplus.com.

- First Choice VIP Care Plus is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.
- Under First Choice VIP Care Plus you can get your Medicare and Healthy Connections Medicaid services in one health plan. A First Choice VIP Care Plus care coordinator will help manage your health care needs.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the *Member Handbook*.
- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios al Miembro de First Choice VIP Care Plus al 1-888-978-0862 (TTY 711), los siete días de la semana, de 8 a.m. a 8 p.m. La llamada es gratuita.
- **You can get this document for free in other formats, such as large print, braille, or audio. Call 1-888-978-0862 (TTY 711), seven days a week, 8 a.m. to 8 p.m., Eastern Time (ET). The call is free.**
- You can request to get this document, now and in the future, in a language other than English or in another format simply by calling Member Services at the number at the bottom of the page. We'll also ask for your preference during our Welcome Call and later in the year, when you contact the plan. The plan will store your request and continue to send future documents in this requested language or format, unless you ask us to cancel or change the request. You can cancel or change your request at any time, simply by calling Member Services. The calls are free.

B. Frequently Asked Questions

The following chart lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicare-Medicaid Plan?	A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Healthy Connections Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Healthy Connections Medicaid. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.
What is a First Choice VIP Care Plus care coordinator?	A First Choice VIP Care Plus care coordinator is one main person for you to contact. This person helps manage all your providers and services and makes sure you get what you need.
What are long-term services and supports?	Long-term services and supports (LTSS) are a variety of services and supports that help people meet their daily needs for assistance and improve the quality of their lives. LTSS are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, and making food. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital.

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Frequently Asked Questions (FAQ)	Answers
Will I get the same Medicare and Medicaid benefits in First Choice VIP Care Plus that I get now?	You will get your covered Medicare and Healthy Connections Medicaid benefits directly from First Choice VIP Care Plus. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. You will get almost all of your covered Medicare and Healthy Connections Medicaid benefits directly from First Choice VIP Care Plus, but you may get some benefits the same way you do now, outside of the plan. This plan also offers services that are not usually covered by Medicare or Healthy Connections Medicaid. When you enroll in First Choice VIP Care Plus, you and your care team will work together to develop an Individualized Care Plan (ICP) to address your health and support needs. During this time, you can keep using the providers you use now for 180 days. You can also continue to get the same services and any that were authorized prior to your enrollment in First Choice VIP Care Plus. When you join our plan, if you are taking any Medicare Part D prescription drugs that First Choice VIP Care Plus does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for First Choice VIP Care Plus to cover your drug, if medically necessary.

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Frequently Asked Questions (FAQ)	Answers
Can I use the same doctors I use now?	Often that is the case. If your providers (including doctors, therapists, and pharmacies) work with First Choice VIP Care Plus and have a contract with us, you can keep using them. • Providers with an agreement with us are "in-network." **You must use the providers in First Choice VIP Care Plus's network.** • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of First Choice VIP Care Plus's plan. To find out if your doctors are in the plan's network, call Member Services or read First Choice VIP Care Plus's *Provider and Pharmacy Directory* on the plan's website at www.firstchoicevipcareplus.com. If First Choice VIP Care Plus is new for you, you can continue using the doctors you use now for 180 days after you first enroll, even if they are out-of-network. If you need to continue using your out-of-network providers after your first 180 days in our plan, we will only cover that care if the provider enters a single case agreement with us. If you are getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact Member Services at **1-888-978-0862 (TTY 711)** , seven days a week, 8 a.m. to 8 p.m.(ET)
What happens if I need a service but no one in First Choice VIP Care Plus's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, First Choice VIP Care Plus will pay for the cost of an out-of-network provider.

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Frequently Asked Questions (FAQ)	Answers
Where is First Choice VIP Care Plus available?	The service area for this plan includes counties in South Carolina. You must live in one of these areas to join the plan. Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Jasper, Kershaw, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg
Do I pay a monthly amount (also called a premium) under First Choice VIP Care Plus?	You will not pay any monthly premiums to First Choice VIP Care Plus for your health coverage.
What is prior authorization (PA)?	PA means that you must get approval from First Choice VIP Care Plus before you can get a specific service or drug or use an out-of-network provider. First Choice VIP Care Plus may not cover the service or drug if you don't get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. Refer to Chapter 3, of the *Member Handbook* to learn more about PA. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a PA.

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Frequently Asked Questions (FAQ)	Answers
What is a referral?	A referral means that your primary care provider (PCP) must give you approval before you can use someone who is not your PCP or use other providers in the plan's network. If you don't get approval, First Choice VIP Care Plus may not cover the services, and you may be billed for these services. You don't need a referral to use some specialists, such as women's health specialists. Refer to Chapter 3, of the *Member Handbook* to learn more about when you will need to get a referral from your PCP.
Do I pay a deductible?	No. You do not pay deductibles in First Choice VIP Care Plus.
Who should I contact if I have questions or need help?	**If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call First Choice VIP Care Plus Member Services at the number at the bottom of the page.** Member Services also has free language interpreter services available for people who do not speak English. **If you have questions about your health, please call the Nurse Advice Call line:** **CALL** **1-855-843-1147** Calls to this number are free. 24 hours a day, seven days a week. **TTY** **711** Calls to this number are free. 24 hours a day, seven days a week.

C. Overview of Services

The following chart is a quick overview of what services you may need, your costs and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor	Visits to treat an injury or illness	$0	
	Wellness visits, such as a physical	$0	
	Specialist care	$0	
	Care to keep you from getting sick, such as flu shots	$0	
	"Welcome to Medicare" preventive visit (one time only)	$0	
You need medical tests (This service is continued on the next page)	Lab tests, such as blood work	$0	Not all lab services will require authorization. Ask your provider to call the plan to confirm if an authorization is required.
	X-rays or other pictures, such as CAT scans	$0	Not all x-rays, outpatient diagnostic procedures, and tests will require authorization. Ask your provider to call the plan to confirm if an authorization is required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests (continued)	Screening tests, such as tests to check for cancer	$0	
You need drugs to treat your illness or condition (This service is continued on the next page)	Generic drugs (no brand name)	$0 for a 30-day supply.	There may be limitations on the types of drugs covered. Please refer to First Choice VIP Care Plus's *List of Covered Drugs* (Drug List) for more information. Extended-day (up to 100-day) supplies are available for many drugs at all network retail locations for the same $0 cost as a 30-day supply. Mail-order pharmacy allows fills of a 61–100-day supply at the same cost for a 30-day supply.
	Brand name drugs	$0 for a 30-day supply.	There may be limitations on the types of drugs covered. Please refer to First Choice VIP Care Plus's *List of Covered Drugs* (*Drug List*) for more information. Extended-day (up to 100-day) supplies are available for many drugs at all network retail locations for the same $0 cost as a 30-day supply. Mail-order pharmacy allows fills of a 61–100-day supply at the same cost for a 30-day supply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Over-the-counter drugs	$0	There may be limitations on the types of drugs covered. Please refer to First Choice VIP Care Plus's *List of Covered Drugs (Drug List)* for more information. Naloxone is covered as a Part C OTC benefit. **The Supplemental OTC Benefit** includes up to $100 per quarter that may be spent for over-the-counter (OTC) items included in the OTC catalog and or online via the ordering portal. Any unused balance will automatically expire at the end of each quarter or upon disenrollment from the plan.
	Medicare Part B prescription drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs. Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization required.
	Chiropractic services (only for manual manipulation for certain approved conditions)	$0	
You need emergency care	Emergency room services	$0	Emergency room services are provided without prior authorization requirements, even if the services are provided out of network.
	Ambulance services	$0	Prior authorization **is not** required for emergency ambulance services. Non-emergency ambulance services between an acute facility and a sub-acute facility do not require prior authorization. Prior authorization required for all other non-emergency ambulance services.
	Urgent care	$0	Urgent care services are provided without prior authorization requirements, even if the services are provided out of network.
You need hospital care	Hospital stay	$0	Prior authorization required.
	Doctor or surgeon care	$0	Prior authorization required for inpatient and outpatient hospital services.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting better or have special health needs	Rehabilitation services	$0	Prior authorization required for cardiac and pulmonary rehabilitation services.
	Medical equipment for home care	$0	Prior authorization required for some medical equipment for home care. Have your provider call the plan to confirm if authorization is required.
	Skilled nursing care	$0	Medicare-covered stays (for example, rehabilitation) require a PA, while Healthy Connections Medicaid-covered stays (for example, long term skilled nursing facility (SNF) stays) only require a referral. Prior authorization required for Medicare-covered SNF services.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care	Treatment for eye injuries or diseases	$0	
	Initial replacement of lens due to cataract surgery	$0	
	Routine eye exam	$0	One exam every year, excluding contact lens exam and fitting services. The routine eye exam does not include a contact lens eye exam.
	Eyewear (eyeglasses/contact lenses)	$0	One pair of eyeglasses (lenses and frames) or one pair of contact lenses is covered every two years. There is up to $150 coverage limit that can be applied towards eyeglasses or contact lenses every two years. The plan will pay for corrective lenses and frames, and replacements if you need them after a cataract removal without a lens implant.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care	Emergency medical procedures by oral surgeons	$0	Prior authorization required for Inpatient Hospital and Ambulatory Surgical Center Services.
	Dental procedures related to organ transplants, cancer, joint replacement, heart valve replacement, and trauma	$0	Prior authorization required.
You need foot care	Podiatry services	$0	
You need hearing/auditory services **(This service is continued on the next page)**	Hearing screenings	$0	Covered hearing screenings are for medically necessary diagnostic hearing and balance exams that are covered by Original Medicare. In addition to the Medicare-covered hearing benefit, the plan also covers: • $0 for up to one routine hearing exam every year • $0 for 80 batteries per hearing aid for non-rechargeable models every three years Up to $1,500 toward the cost of non-implantable hearing aid(s) from the applicable TruHearing® Choice catalog every 3 years After plan-paid benefit, you are responsible

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/auditory services (continued)			for the remaining costs. You must see a TruHearing® provider to use this benefit. Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries • Hearing aids that are not in the applicable TruHearing® catalog • Costs associated with loss and damage warranty claims

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a chronic condition, such as diabetes or heart disease	Services to help manage your disease	$0	
	Diabetes supplies and services	$0	Diabetic supplies and services are limited to specific manufacturers. Preferred and Non-preferred Continuous Glucose Monitors (CGM) will require prior authorization. Non-preferred brands will require an authorization.
	Cardiac and pulmonary rehabilitation services	$0	Prior authorization required.
You have a mental health condition	Mental or behavioral health services	$0	Referral required for Healthy Connections Medicaid-covered outpatient mental health services. Referral required for Institution for Mental Disease Services for individuals 65 years or older.
	Partial hospitalization	$0	Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance abuse problem	Substance abuse services	$0	Medicare Part B helps pay for outpatient substance abuse treatment services from a clinic or hospital outpatient department. Covered services include, but are not limited to: • Psychotherapy • Patient education • Follow-up care after you leave the hospital • Prescription drugs during a hospital stay or injected at a doctor's office. • Preventive screening and counseling Prior authorization required. Not all outpatient substance abuse services will require an authorization. Have your provider call the plan to confirm if an authorization is required.
You need long-term mental health services	Inpatient care for people who need mental health care	$0	Prior authorization required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME)	Wheelchairs Crutches IV infusion pumps Oxygen equipment and supplies Nebulizers Walkers	$0	The copay is $0 for covered durable medical equipment. White canes for the blind are not covered. Note: Our plan will rent most DME items for you for a maximum of 10 months. In some cases, it may be 13 months. At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. Refer to Chapter 3 of the *Member Handbook* for more information. Prior authorization from Healthy Connections Medicaid is required. However, case managers from Community and Long Term Care (CLTC) may authorize durable medical equipment for waiver participants. Prior authorization required for all DME items.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need prosthetics	Prosthetic devices	$0	The copay is $0 for covered prosthetic devices/medical supplies. Prior authorization required.
You need help living at home (This service is continued on the next page)	Meals brought to your home	$0	This service is provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver. State eligibility requirements may apply. Maximum of two meals per day. Prior authorization required for the waiver meal benefit.
	Homemaker services, such as cleaning or housekeeping	$0	These services are provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver. State eligibility requirements may apply. Prior authorization required. Referral required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	Changes to your home, such as ramps and wheelchair access	$0	Environmental modifications benefit has a $7,500 lifetime limit. These services are provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver. State eligibility requirements may apply. Prior authorization required.
	Personal care services (You may be able to choose your own aide. Call Member Services for more information.)	$0	50 visits per year. State eligibility requirements may apply. This benefit can be offered as a supplemental benefit to non-waiver enrollees. No copay will be applied to the supplemental benefit. Your care coordinator can authorize these services. Prior authorization required.
	Home health care services	$0	The copay is $0 for covered home health care services. Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	Services to help you live on your own	$0	Prior authorization required. Referral required.
	Adult day services or other support services	$0	These services are provided only to members enrolled in the Community Choices waiver. State eligibility requirements may apply. Prior authorization required. Referral required.
You need a place to live with people available to help you	Nursing home care	$0 or amount based on income	You must contribute toward the cost of this service when your income is more than an allowable amount. This contribution, known as the patient pay amount, is required only for those living in a nursing home. You will not need to pay if you are in the nursing home for short-term rehabilitation. Medicaid-covered stays (for example, long-term stays in a nursing home) require CLTC certification prior to an admission to a nursing home. .

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Your caregiver needs some time off	Respite care	$0	Respite care can be provided in a Community Residential Care Facility (CRCF), a nursing facility, or at your home. Members are limited to 28 total days of respite care per year. Up to 28 days of respite care can be in a CRCF. Up to 14 days of respite care can be in a nursing facility. Up to 14 days of respite care can be in your home. (Mechanical Ventilator Dependent waiver only.) The type of care you are qualified to get will depend on your situation. This benefit can be offered as a supplemental benefit to non-waiver members. Your care coordinator can authorize these services. Prior authorization required. Referral required.
You need care for advanced illness or life-threatening injury	Palliative care	$0	Prior authorization required. Referral required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need family planning services	Birth control (condoms)	$0	Family planning supplies are covered only with a prescription.
	Family planning lab and diagnostic tests	$0	
	Treatment for sexually transmitted infections (STIs)	$0	
Additional covered services (This service is continued on the next page)	Education and wellness programs	$0	
	End-stage renal disease services	$0	
	Fitness benefit	$0	SilverSneakers® is a fitness benefit, which includes access to participating Silver Sneakers fitness facilities, online wellness resources, and classes, at no additional cost.
	Infusion services	$0	Prior authorization required.
	Nursing home transition services	$0	Prior authorization required. Referral required.
	Preventive services	$0	
	Services provided at Federally Qualified Health Centers	$0	
	Targeted case management	$0	Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)	Telehealth	$0	MDLive offers all members 24/7 access throughout the year to a participating doctor via telephone, desktop, or mobile device. Members have the ability to immediately have a medical, counseling, or psychiatry consultation with a physician. Members can also schedule a telemedicine appointment for a later time.
	Telemedicine	$0	The plan covers some medical or health services using real-time audio or video with a provider who isn't at your location. These services are available in some rural areas, under certain conditions, and only if you're located at one of the following places: a doctor's office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility (SNF), or community mental health center. A referral is required.

D. Benefits covered outside of First Choice VIP Care Plus

This is not a complete list. Call Member Services to find out about other services not covered by First Choice VIP Care Plus but available through Medicare or Healthy Connections Medicaid.

Other services covered by Medicare or Healthy Connections Medicaid Please contact your care coordinator for more information	**Your costs**
Some hospice care services	$0
Dental services • Diagnostics (oral evaluation and x-rays) • Preventive care (annual cleaning) • Restorative care (fillings) • Surgical care (extractions / removals)	$0
Non-emergency medical transportation	$0

E. Services that First Choice VIP Care Plus, Medicare, and Healthy Connections Medicaid do not cover

This is not a complete list. Call Member Services to find out about other excluded services.

Services not covered by First Choice VIP Care Plus, Medicare, or Healthy Connections Medicaid	
Chiropractic care (except manual manipulation for certain approved conditions)	Non-prescription contraceptive supplies
Certain visual procedures such as LASIK	Orthopedic shoes (unless included with brace or for diabetic foot disease). Supportive devices for feet (except for diabetic foot disease)
Cosmetic surgery or cosmetic work	Personal items in your hospital or nursing home room
Dentures	Private room in hospital
Elective or voluntary enhancement procedures or services	Routine foot care (except for certain approved conditions)
Experimental medical and surgical treatments, items and drugs	Services not considered “reasonable and necessary”
Full-time nursing care in your home	Services provided to veterans in a VA facility
Naturopath services	Surgical treatment for morbid obesity

F. Your rights as a member of the plan

As a member of First Choice VIP Care Plus, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness and dignity.** This includes the right to:
  - get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
  - get information in other formats (e.g., large print, braille, audio)
  - be free from any form of physical restraint or seclusion used as a means of coercion, discipline, convenience, a perceived safety measure, or retaliation
  - not be billed by network providers
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a format you can understand. These rights include getting information on:
  - description of the services we cover
  - how to get services
  - how much services will cost you
  - names of health care providers and care managers
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - choose a Primary Care Provider (PCP) and change your PCP at any time
  - use a women's health care provider without a referral
  - get your covered services and drugs quickly
  - know about all treatment options, no matter what they cost or whether they are covered
  - refuse treatment, even if your doctor advises against it
  - stop taking medicine
  - ask for a second opinion. First Choice VIP Care Plus will pay for the cost of your second opinion visit

- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - get timely medical care
  - get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act.
  - have interpreters to help with communication with your doctors and your health plan
- **You have the right to emergency and urgent care when you need it.** This means you have the right to:
  - get emergency services without PA in an emergency
  - use an out-of-network or urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - have your personal health information kept private
- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - file a complaint or grievance against us or our providers
  - ask for a state fair hearing
  - get a detailed reason for why services were denied

For more information about your rights, you can read the First Choice VIP Care Plus *Member Handbook*. If you have questions, you can also call First Choice VIP Care Plus Member Services.

G. How to file a complaint or appeal a denied service

If you have a complaint or think First Choice VIP Care Plus should cover something we denied, call First Choice VIP Care Plus at **1-888-978-0862 (TTY 711).** You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the First Choice VIP Care Plus *Member Handbook*. You can also call First Choice VIP Care Plus Member Services.

If you would like to contact First Choice VIP Care Plus about a complaint, grievance, or appeal, mail or call us at:

Appeals:
First Choice VIP Care Plus
ATTN: Appeals Department
P.O. Box 80109
London, KY 40742-0109

Grievances and complaints:
First Choice VIP Care Plus
Attn: Customer Experience, Grievances, and Complaints
P.O. Box 7140
London, KY 40742-7140

Phone number: **1-888-978-0862 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m. (ET).

There is a special ombudsman for this program called the Healthy Connections Prime Advocate. The Healthy Connections Prime Advocate does not work for us or Healthy Connections Medicaid. They can help you understand your rights and the appeal process, and they can help you with your appeal. You can reach the Healthy Connections Prime Advocate at **1-844-477-4632**.
TTY users should call **711**.

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at First Choice VIP Care Plus Member Services. Phone numbers are at the bottom of the page and on the cover of this summary, **or**
- Call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.
- Call Healthy Connections Medicaid at **1-888-364-3224** or email your concerns to **fraudres@scdhhs.gov.**

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