Jefferson Health Plans Special (HMO D-SNP) offered by Jefferson Health Plans

Annual Notice of Changes for 2025

You are currently enrolled as a member of Jefferson Health Plans Special (HMO-D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.JeffersonHealthPlans.com/medicare. You may also call Member Relations to ask us to mail you an *Evidence of Coverage*.

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in Jefferson Health Plans Special (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Jefferson Health Plans Special (HMO D-SNP).
- Look in section 2.2, page 10 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member Relations number at 1-866-901-8000 for additional information. (TTY users should call 1-877-454-8477.) Hours are 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. This call is free.
- You can also request this information in alternate formats (such as braille, large print or audio) by calling Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477).
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Jefferson Health Plans Special (HMO D-SNP)

- Jefferson Health Plans contracts with Medicare to offer HMO, HMO-DSNP, and PPO plans. Our HMO-DSNP also has a contract with the Pennsylvania State Medicaid program. Enrollment in our plans depends on contract renewal. The plan also has a written agreement with the Pennsylvania Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Jefferson Health Plans. When it says "plan" or "our plan," it means Jefferson Health Plans Special (HMO D-SNP).

Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Jefferson Health Plans Special (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $40.20.	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $48.40.
Doctor office visits	Primary care visits: $0 coinsurance per visit. Specialist visits: $0 coinsurance per visit.	Primary care visits: $0 coinsurance per visit. Specialist visits: $0 coinsurance per visit.
Inpatient hospital stays	You pay a $0 deductible; $0 copay each day for days 1 - 60; $0 copay each day for days 61 - 90; $0 copay each day for days 91+ (up to 60 lifetime reserve days).	You pay a $0 deductible; $0 copay each day for days 1 - 60; $0 copay each day for days 61 - 90; $0 copay each day for days 91+ (up to 60 lifetime reserve days).
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: • Generic Drugs: $0 copay • All other drugs: $0 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: • Generic Drugs: $0 copay • All other drugs: $0 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.
Maximum out-of-pocket amount	$8,850	$8,850

Cost	2024 (this year)	2025 (next year)
This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $40.20	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $48.40

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount	$8,850	$8,850
Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.		Once you have paid $8,850 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services

Cost	2024 (this year)	2025 (next year)
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.		for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.JeffersonHealthPlans.com/medicare. You may also call Member Relations for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are no changes to our network of providers for next year.

There are changes to our network of pharmacies for next year. **Please review the 2025 *Provider & Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Relations so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2025 Evidence of Coverage*. A copy of the *Evidence of Coverage* is located on our website at www.JeffersonHealthPlans.com/medicare. You may also call Member Relations to ask us to mail you an *Evidence of Coverage*.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Flex card	You are covered for up to $315 per quarter for food and utility payment support. See your *Evidence of Coverage* for details.	You are covered for up to $260 per quarter for food and utility payment support. See your *Evidence of Coverage* for details.
Over-the-Counter (OTC) Items	You are covered up to $315 per quarter for eligible	You are covered up to $300 per quarter for eligible

Cost	2024 (this year)	2025 (next year)
	over-the-counter items. Unused amounts will *not* be rolled over.	over-the-counter items. Unused amounts will *not* be rolled over.
Healthy Meals	Not Covered	Member will be able to receive 14 meals a year, please reach out to the health plan for additional information.
Non-Medical Transportation	Not Covered	12 non-medical trips (to grocery store, fitness center, senior community center, and/or bank/ post office, etc.)
Vision	You pay a $0 copay for your choice of one of the following, up to $500 yearly: • one pair of eyeglasses (lenses and frames) • contact lenses up to the allowance	You pay a $0 copay for your choice of one of the following, up to $250 yearly: • one pair of eyeglasses (lenses and frames) • contact lenses up to the allowance
Value-Based Items and Services		
Flexible Spending / Meals / Non-Medical Transportation / Rewards For eligible members (those with Medicare's Low Income Subsidy level 1, 2, 3 and those members living in certain Area Deprivation Index deciles 7-10 neighborhoods/communities who may not be eligible solely based on their Medicare's Low Income Subsidy level status.), certain produce and other food items are covered. For these members:		
1. Flexible Spending: allowance can also be used to purchase covered food and produce items or general supports for living. Unused amounts cannot be rolled over from one calendar quarter to another. **2. Healthy Meals:** eligible members will be able to receive a set number of annual meals. Unused amounts cannot be rolled over from one calendar year. **3. Non-Medical Transportation:** Members will be provided a set number of rides to non-medical visits using set locations such as grocery, fitness, community centers, and enrollee advisory committee meetings. Unused amounts cannot be rolled over from one calendar year.		

Cost	2024 (this year)	2025 (next year)
4. Medication adherence rewards: The cholesterol, diabetes, or hypertension medication adherence rewards the plan asks members to take the following action: Note: Jefferson Health Plans offers these benefits through our participation in Medicare's Value-Based Insurance Design program. The food and produce Meals, Transportation, and Rewards option is not a Medicare or plan-covered benefit.		

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically. The Drug List includes many—but not all—of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website www.JeffersonHealthPlans.com/medicare.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Relations for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your Evidence of Coverage. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/ biosimilars/multimedia-education-materials- biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Beginning in 2025, there are three drug payment stages: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $0.	The deductible is $0.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this chart are for a one-month supply when you fill your prescription at a network pharmacy.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Generic Drugs:*** You pay $0 per prescription. ***All other drugs:*** You pay $0 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Generic Drugs:*** You pay $0 per prescription ***All other Drugs:*** You pay $0 per prescription

Stage	2024 (this year)	2025 (next year)
For information about the costs for a long-term supply; or at a network pharmacy that offers preferred cost sharing, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our "Drug List". To see if your drugs will be in a different tier, look them up on the "Drug List". Most adult Part D vaccines are covered at no cost to you.	_____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $2,000, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Jefferson Health Plans Special (HMO D-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Jefferson Health Plans Special (HMO D-SNP) plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Jefferson Health Plans offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Jefferson Health Plans Special (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Jefferson Health Plans Special (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Relations if you need more information on how to do so.
  - *OR* 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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug

coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. PA MEDI counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call PA MEDI at 1-800-783-7067. You can learn more about PA MEDI by visiting their website (www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx).

For questions about your Medicaid benefits, contact Medicaid at 1-800-692-7462, TTY 1-800-451-5886, Monday - Friday, 8:30 a.m. - 5:30 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office.

- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called Pharmaceutical Assistance Contract for the Elderly (PACE) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Special Pharmaceutical Benefit Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-922-9384.

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at *(855) 582-2023* or visit Medicare.gov.

SECTION 6 Questions?

Section 6.1 – Getting Help from Jefferson Health Plans Special (HMO D-SNP)

Questions? We're here to help. Please call Member Relations at 1-866-901-8000. (TTY only, call 1-877-454-8477.) We are available for phone calls 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. Calls to these numbers are free.

Read your 2025 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the 2025 *Evidence of Coverage* for Jefferson Health Plans Special (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.JeffersonHealthPlans.com/medicare. You may also call Member Relations to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.JeffersonHealthPlans.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our *List of Covered Drugs (Formulary/Drug List)*.

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Pennsylvania Department of Human Services at 1-800-692-7462. TTY users should call 1-800-451-5886.