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CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Guide to Medicare's
**Preferred Provider
Organization (PPO)
Plans**

This official government booklet has important information about the following:

- ★ Understanding Medicare PPO Plans
- ★ Joining and switching Medicare PPO Plans
- ★ Other important information on Medicare PPO Plans



“Your Guide to Medicare’s Preferred Provider Organization Plans” isn’t a legal document. Official Medicare Program legal guidance is are contained in the relevant statutes, regulations, and rulings.

The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date version, visit www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication,” or, call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

Section 1: Medicare Preferred Provider Organization Plan (PPO) Basics 3–5

- What is a Medicare PPO Plan? 4
- How do Medicare PPO Plans work? 5
- How are Medicare PPO Plans, Health Maintenance Organizations (HMOs), and the Original Medicare Plan different? 6

Section 2: Medicare Preferred Provider Plan (PPO) Costs 7–9

- What are the costs of being in a Medicare PPO? 8
- How do out-of-pocket costs vary? 9

Section 3: Joining and Switching Medicare Preferred Provider Organization (PPO) Plans 11–14

- Who can join a Medicare PPO Plan? 12
- When can I join, switch, or drop a Medicare PPO Plan? 12
- How do I join a Medicare PPO Plan? 13
- How do I switch Medicare PPO Plans? 13
- What if I move out of the plan’s service area? 14
- What happens if my Medicare PPO Plan leaves the Medicare Program? 14

Section 4: Medicare Medicare Preferred Provider Organization (PPO) Plan Covered Services 15–16

- What services must a Medicare PPO Plan cover? 16
- How do I know if a service I need is medically necessary? 16
- Can I get care when I travel or am away from the plan’s service area? 16

Section 5: Appeal Rights 17–18

- What can I do if my Medicare PPO Plan won’t pay for a service I think is medically necessary? 18

Section 6: Medigap Information 19–22

Can I keep my Medigap policy if I join a Medicare PPO Plan? 20

What happens if my Medicare PPO Plan coverage ends? 20

What happens if my Medicare PPO Plan coverage ends, and I have
End-Stage Renal Disease? 21Do I have any Medigap protections if I drop my Medigap policy
when I join a Medicare PPO Plan? 21

Are there any other times I have a right to buy a Medigap policy? 22

Where can I get more information about Medigap policies and protections? . . . 22

Section 7: For More Information 23–25

Where can I get more information about Medicare PPO Plans? 24

For More Information 25

Section 8: Words to Know 27–28**Section 9: Index Inside back cover**

Medicare Preferred Provider Organization Plan Basics



You can get your Medicare benefits in different ways. This booklet gives you general information on one of these options, Medicare's Preferred Provider Organization (PPO) Plans. However, you will need more information than this booklet can give you to decide if a Medicare PPO Plan would meet your needs. This booklet will help you ask questions to get the information you need to make your plan choice. Remember, if you join a Medicare PPO Plan, you are still in the Medicare Program.

What is a Medicare PPO Plan?

A Medicare PPO Plan is a [Medicare Advantage Plan](#) offered by a private insurance company. Medicare pays a set amount of money every month to the private insurance company to provide health care to people with Medicare. A Medicare PPO Plan has a list (called a “[network](#)”) of primary care doctors, specialists, and hospitals that you may go to. You can go to any doctor, specialist, or hospital not on the plan's list, but it will usually cost more.

Some Medicare PPO Plans offer prescription drug coverage. Some plans also offer additional benefits, such as vision and hearing screenings, disease management, and other services not covered under the [Original Medicare Plan](#). Monthly [premiums](#) and how much you pay for services vary depending on the plan.

There are two types of Medicare PPO Plans:

- **Regional Preferred Provider Organizations Plans**—these plans serve one of 26 regions decided by Medicare (these may be a single state or multi-state area)
- **Local Preferred Provider Organizations Plans**—these plans serve the counties the PPO Plan chooses to include in its service area

Regional PPO Plans have an added protection for [Medicare Part A](#) (Hospital Insurance) and [Part B](#) (Medical Insurance) benefits. There is an annual limit on your out-of-pocket costs. This limit varies depending on the plan.

Note: You can get your Medicare prescription drug coverage from your Medicare PPO Plan if your plan offers prescription drug coverage. Insurance companies offering a Medicare PPO Plan are required to offer a plan that includes Medicare prescription drug coverage. **If you join a Medicare PPO Plan that doesn't include such coverage, you can't join a [Medicare Prescription Drug Plan](#).**

How do Medicare Preferred Provider Organization (PPO) Plans work?

- Each plan has a list (called a “**network**”) of doctors, hospitals, and other providers that you may go to.
- Each plan gives you flexibility to go to doctors, specialists, or hospitals that aren’t on the plan’s list, but it will usually cost more.
- You may get care from specialists without a referral or prior authorization from another doctor. If you use plan specialists, your costs for covered services will usually be lower than if you use non-plan specialists.
- Each plan may choose to offer a discount to members if they voluntarily use preauthorization or if they pre-notify the plan when getting out-of-network services.
- You get all services covered under **Medicare Part A** and **Part B**, although the amount you pay for these services might not be the same as under the **Original Medicare Plan**.
- Each plan can charge you a monthly **premium** amount above and beyond the Medicare Part B premium.
- Each plan can charge **deductible** and **coinsurance** amounts that are different than those under the Original Medicare Plan.
- In a Regional PPO Plan, you have an added protection for Medicare Part A and Part B benefits. There is an annual limit on your out-of-pocket costs. This limit varies depending on the plan.
- Medicare PPO Plans operate like Health Maintenance Organizations (HMOs) except in HMOs you can only go to doctors, hospitals, and specialists that are part of the plan’s network, and often HMOs require referrals and preauthorizations.

Remember, words in **green** are defined on pages 27–28.

How are Medicare Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and the Original Medicare Plan different?

	Medicare PPO	Medicare HMO	Original Medicare Plan
Premiums: Will I have to pay more than the monthly Part B premium to be in the plan?	Generally, yes	Generally, yes	No
Extra benefits: Does the plan cover more benefits than Medicare Part A and Part B?	Generally, yes	Generally, yes	No, unless you buy a Medigap policy* to cover services the Original Medicare Plan doesn't cover
Providers: Can I go to providers who aren't part of the plan's network?	Yes, but if you go to out-of-network providers, you will usually have to pay more.	No	Yes

* It is illegal for someone to sell you a Medigap policy if you are in a Medicare HMO or PPO Plan.

2

Medicare Preferred Provider Organization Plan (PPO) Costs



What are the costs of being in a Medicare PPO Plan?

In a Medicare PPO Plan, you pay the following:

- The monthly **Medicare Part B premium** (\$96.40 in 2008)
- A monthly premium that includes coverage for Part A and Part B benefits, prescription drug coverage (if offered), and extra benefits (if offered) above the Medicare Part B premium
- Any plan **deductible**, **coinsurance**, or **copayment** amounts that the plan charges. For example, the plan may charge a set amount (copayment) of \$10 or \$20 every time you see a doctor.
- A maximum amount (cap) you have to pay for out-of-pocket costs for both in- and out-of-network care in a Regional PPO. In a local PPO, the PPO Plan may or may not choose to have a cap.

Example:

Mrs. Smith is thinking about joining a Medicare PPO Plan. The PPO Plan has a \$75 monthly premium, but covers additional benefits the **Original Medicare Plan** doesn't cover. To be in the plan, Mrs. Smith would have to pay the monthly Medicare Part B premium (\$96.40 in 2008) and the additional monthly premium (\$75) the plan charges. This plan also charges \$10 for every doctor visit. If Mrs. Smith goes to her in-network doctor three times in one month, she would have to pay \$96.40 to Medicare, \$75 to her PPO Plan, and \$30 (\$10 per visit) to her doctor for that month. Her total costs for that month would be \$201.40 (\$96.40 + \$75 + \$30).

How do out-of-pocket costs vary?

Medicare PPO Plans differ in the amount they charge for **premiums**, **deductibles**, and services. The PPO Plan (rather than Medicare) decides how much you pay for the covered services you get. Contact the plan before you get services to find out how much you will have to pay and if the service you want is covered.

Generally, you will get more benefits for lower costs than the **Original Medicare Plan**. However, you may be able to get extra benefits for an additional premium. Every Medicare PPO Plan must pay for all **medically-necessary** covered services, but every plan is different in what you must pay. Contact the Medicare PPO Plan you are interested in to find out more.

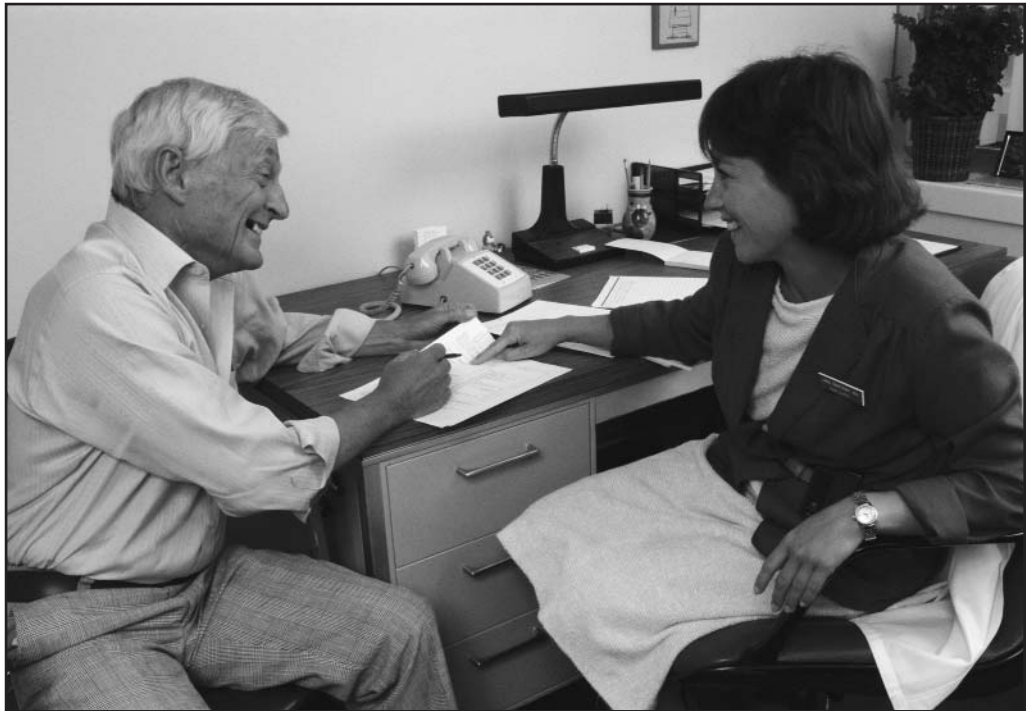
Your costs depend on the following:

- Which Medicare PPO Plan you choose
- Whether the plan charges an additional monthly premium
- Whether the doctors, hospitals, and other providers you go to are part of or outside of your plan's network
- How much the plan charges per visit
- How often and the type of health care you get
- Which extra benefits are covered by the plan

Remember,
words in
green are
defined on
pages 27–28.

3

Joining and Switching Medicare Preferred Provider Organization (PPO) Plans



Who can join a Medicare PPO Plan?

You can generally join if you meet these conditions:

- You have Part A and Part B.
- You live in the service area of the plan.
- You don't have [End-Stage Renal Disease](#) (permanent kidney failure requiring dialysis or a kidney transplant) except as explained on page 21.

Note: In most cases, you can join a Medicare PPO Plan only at certain times.

When can I join, switch, or drop a Medicare PPO Plan?

You can join, switch, or drop a Medicare PPO Plan at the following times:

1. When you first become eligible for Medicare (3 months before you turn age 65 to 3 months after the month you turn age 65)
2. If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability benefits.
3. From November 15–December 31 each year. Your coverage will begin on January 1 of the following year.
4. From January 1–March 1 of each year. However, you can't add or change to a plan with prescription drug coverage during this time unless you already have Medicare prescription drug coverage.

Remember, words in [green](#) are defined on pages 27–28.

Note: In certain situations, you may be able to join, switch, or drop [Medicare Advantage Plans](#) at other times (like if you move out of the service area, have both Medicare and [Medicaid](#), or live in an institution).

How do I join a Medicare PPO Plan?

Once you choose a Medicare PPO Plan, you may be able to join by completing a paper application, calling the plan, or enrolling online. Talk with the plan to find out how you can join. When you join a Medicare PPO Plan, you will have to provide your Medicare number from your Medicare card and the date your [Medicare Part A](#) and/or [Part B](#) coverage started.

How do I switch Medicare PPO Plans?

If you are already in a [Medicare Advantage Plan](#) and want to switch during one of the times listed on page 12, this is what you need to do:

- To switch to the [Original Medicare Plan](#), contact your current plan or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- To switch to a new Medicare Advantage Plan, simply join the plan you choose during one of the periods listed on page 12. You will be disenrolled automatically from your old plan when your new plan's coverage begins.

Remember, no one should call you or come to your home uninvited to sell Medicare-covered products. If you believe a plan misled you, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember,
words in
[green](#) are
defined on
pages 27–28.

What if I move out of the plan's service area?

If you permanently move out of the plan's service area, you may have to switch to another plan. However, you can call your current plan to see if you can stay with them even though you have moved. If you must switch to another plan, you can choose to join another [Medicare Advantage Plan](#) or another Medicare Health Plan if one is available in your new area, or you can also return to the [Original Medicare Plan](#). If you move out of the plan's service area and don't join a new plan, you will automatically return to the Original Medicare Plan.

What happens if my Medicare PPO Plan leaves the Medicare Program?

If your Medicare PPO Plan leaves the Medicare Program, the plan will send you a letter about your options. Generally, you will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare Advantage Plan. You will also have the right to buy a Medigap Policy. See pages 19–22.

Remember,
words in
[green](#) are
defined on
pages 27–28.

4

Medicare Preferred Provider Organization (PPO) Plan Covered Services



What services must a Medicare PPO Plan cover?

A Medicare PPO Plan must cover all benefits covered by Medicare Part A and Part B. A PPO Plan must also cover all medically-necessary benefits such as emergency services. They may also cover extra benefits, such as extra days in the hospital—but you may have to pay more for these extra benefits.

How do I know if a service I need is medically necessary?

A Medicare PPO Plan must use Medicare’s coverage rules to decide what services are medically necessary. This means that if a service is medically necessary under the Original Medicare Plan, then the PPO Plan also must cover the service.

Can I get care when I travel or am away from the plan’s service area?

You can get care anywhere in the United States. Remember, if you get care for a non-plan provider, your costs will generally be higher. However, you won’t have to pay more if you are getting care for a medical emergency.

Remember,
words in
green are
defined on
pages 27–28.

5

Appeal Rights



What can I do if my Medicare PPO Plan won't pay for a service I think is medically necessary?

If your plan won't pay for, or doesn't allow a service that you think should be covered, you can file an appeal. If you have Medicare, you have certain guaranteed rights. One of these is the right to a fair process to appeal decisions about health care payment of services. An appeal is a kind of complaint you make if any of the following applies:

- Your plan refuses to pay for a service, item, or prescription drug that you got and think should be covered.
- Your plan has told you in advance that it won't cover a service, item, or prescription drug you think should be covered.
- You disagree with the amount that you have to pay for a service, item, or prescription drug you got.

Note: These appeal rights apply to benefits generally covered by Medicare and extra plan benefits provided by your Medicare PPO Plan.

If you decide to file an appeal, ask your doctor, health care provider, or supplier for any information that may help your case. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. If the plan or physician agrees, the plan must make a decision within 72 hours.

The plan must tell you, in writing, how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan doesn't decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. Contact your plan for details about your Medicare appeal rights.

If you believe you are being discharged from a hospital too soon, you have a right to an immediate review by the [Quality Improvement Organization \(QIO\)](#) in your area. A QIO is a group of doctors and health professionals who monitor and review your complaints about quality of care. You will be able to stay in the hospital while they review your case. The hospital can't force you to leave before the QIO reaches a decision. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for the QIO in your area. TTY users should call 1 877-486-2048.

In addition, you will have the right to a fast-track appeals process when you disagree with a decision that you no longer need services you are getting from a skilled nursing facility, home health agency, or a comprehensive outpatient rehabilitation facility. You will get a notice from your provider that will tell you how to ask for an appeal if you believe that your services are ending too soon. You will be able to obtain a quick review of this decision, with independent doctors looking at your case and deciding if your services need to continue.

6

Medigap Information



Can I keep my Medigap policy if I join a Medicare PPO Plan?

Yes, you may keep it. However, a [Medigap policy](#) only works with the [Original Medicare Plan](#). If you join a [Medicare Advantage Plan](#) (like an HMO or PPO), you generally don't need (and can't use) a Medigap policy. You may want to drop your Medigap policy if you join a Medicare Advantage Plan, but you should talk to your Medigap insurance company before you do. If you already have a Medicare Advantage Plan, it is illegal for anyone to sell you a Medigap policy unless you are switching back to the Original Medicare Plan.

What happens if my Medicare PPO Plan coverage ends?

At the end of the year, plans can decide to leave the Medicare Program. If your plan leaves the Medicare Program, the plan will send you a letter about your options. Generally, you will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare Advantage Plan. You will also have the right to buy a Medigap policy. See page 14. You should learn as much as you can about your choices before making a decision.

No matter what you choose, you are still in the Medicare Program and will get all Medicare-covered services. If your health plan covers prescription drugs and you want to keep getting prescription drug coverage, you need to join another plan that offers this coverage. If you decide to return to the Original Medicare Plan and want to continue to have drug coverage, you will have to join a [Medicare Prescription Drug Plan](#). See page 21 to find out where you can get more information on Medigap policies and protections.

Note: In recent years, very few plans have left the Medicare Program.

What happens if my Medicare PPO Plan coverage ends, and I have End-Stage Renal Disease (ESRD)?

If you have [ESRD](#) and a Medicare PPO Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another [Medicare Advantage Plan](#). You don't have to use your one-time right to join a new plan immediately. If you change directly to the [Original Medicare Plan](#) after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan later, as long as the plan you choose is accepting new members.

For more information about ESRD, visit www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication” to view the booklet “Medicare Coverage of Kidney Dialysis and Kidney Transplant Services.”

Do I have any Medigap protections if I drop my Medigap policy when I join a Medicare PPO Plan?

If you drop your [Medigap policy](#) when you join a Medicare PPO Plan, you may have the right to get another Medigap policy later if either of the following apply:

- Your Medicare PPO Plan coverage ends (through no fault of your own).
- You join a Medicare PPO Plan for the first time (and haven't been in another Medicare Advantage Plan), and within one year of joining, you leave the Medicare PPO Plan. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

Are there any other times I have the right to buy a Medigap policy?

You have the right to buy any [Medigap policy](#) sold in your state if both of the following apply to you:

- You joined a Medicare PPO Plan when you first became eligible for Medicare at age 65.
- You leave the Medicare PPO Plan within one year after joining.

You can apply for the Medigap policy as early as 60 calendar days before the date your coverage ends. You must apply for the Medigap policy no later than 63 calendar days after your Medicare PPO Plan coverage ends.

Where can I get more information about Medigap policies and protections?

To get more information about Medigap policies and protections, you can do the following:

- Visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Health Plans and Medigap Policies in Your Area.”
- Call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.” This guide gives information on buying a Medigap policy and information on your Medigap rights and protections.
- Call your [State Health Insurance Assistance Program](#). See page 25. This state program gets money from the Federal government to give free local health insurance counseling to people with Medicare.

For More Information



Where can I get more information about Medicare Preferred Provider Organization (PPO) Plans?

For more information about Medicare PPO Plans or to find out what plans are available in your area, you can do the following:

- Visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Health Plans and Medigap Policies in Your Area.” If you don’t have a computer, your local library or senior center may be able to help you access the Medicare website.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the insurance company offering the Medicare PPO Plan you are interested in with any questions you have about the plan. The health plan administrator will be able to send you information about the plan and explain all the benefits the plan offers.
- Call your [State Health Insurance Assistance Program](#). See page 25. This state program gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Remember, words in green are defined on pages 27–28.

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site at www.medicare.gov/contacts/home.asp on the web. Thank you.

8

Words to Know

Coinsurance—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible.

Copayment—In some Medicare health plans and prescription drug plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay. For example, this could be \$10 or \$20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible—The amount you must pay for health care, before the Medicare PPO Plan begins to pay. These amounts can change every year.

End-Stage Renal Disease (ESRD)—Permanent kidney failure requiring dialysis or a kidney transplant.

Medicaid—A joint Federal and State program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan—A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage Plans are HMOs, PPOs, Private Fee-for-Service Plans, Special Needs Plans, or Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under the Original Medicare Plan.

Medicare Part A (Hospital Insurance)—Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that aren't covered by Part A.

Medicare Prescription Drug Plan (Part D)—A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that must follow the same rules as Medicare Prescription Drug Plans.

Medigap Policy—A Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Original Medicare Plan—The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). It is a fee-for-service health plan. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

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

Quality Improvement Organizations (QIOs)—Groups of practicing doctors and other health care experts. They are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by any provider or practitioner providing Medicare-covered services. QIOs also hear certain appeals for people with Medicare.

Service Area—The area where a Medicare PPO Plan accepts members.

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

Appeal	18, 25
Coinsurance.....	5, 8, 20, 27
Copayment	8, 20, 27
Deductible.....	8, 9, 20, 27
End-Stage Renal Disease	12, 21, 27
Medicaid	12, 20, 27
Medically Necessary.....	16, 18, 27
Medicare Advantage Plan	4, 12, 13, 14, 20, 21, 27
Medicare Part A (Hospital Insurance)	4, 5, 6, 16, 27
Medicare Part B (Medical Insurance).....	5, 8, 27
Medigap Policy	6, 14, 20, 21, 22, 25, 28
Network	4, 5, 6, 8, 9
Original Medicare Plan	4, 5, 6, 8, 9, 13, 14, 16, 20, 21, 28
Premium	4, 5, 6, 8, 9, 28
Prescription Drugs.....	4, 8, 12, 18, 20, 28
Quality Improvement Organization	18, 28
Rights	18, 22, 25
Service Area	12, 14, 16, 28
State Health Insurance Assistance Program	22, 24, 25, 28

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