The details of your plan

2023 Evidence of Coverage

Amerivantage Full Dual Coordination (HMO D-SNP)

Customer Service:
1-833-713-1074, TTY: 711

www.amerigroup.com/medicare

Amerigroup

January 1 – December 31, 2023

Evidence of Coverage

Your Medicare health benefits and services and prescription drug coverage as a member of Amerivantage Full Dual Coordination (HMO D-SNP)

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-833-713-1074. (TTY users should call 711.) Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. Customer Service also has free language interpreter services available for non-English speakers.

This plan, Amerivantage Full Dual Coordination (HMO D-SNP), is offered by Amerigroup. (When this Evidence of Coverage says "we," "us" or "our," it means Amerigroup. When it says "plan" or "our plan," it means Amerivantage Full Dual Coordination (HMO D-SNP).)

This document is available to order in braille, large print and audio. To request this document in an alternate format, please call Customer Service at the phone number printed on the back of this booklet.

Benefits, premiums, deductibles and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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Y0114_23_3002583_U_C_0020 CMS Accepted OMB Approval 0938-1051 (Expires: February 29, 2024)

2023 Evidence of Coverage
Table of contents

Chapter 1

Getting started as a member

Section 1. Introduction

Section 1.1

You are enrolled in Amerivantage Full Dual Coordination (HMO D-SNP), which is a specialized Medicare Advantage plan (special needs plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Amerivantage Full Dual Coordination (HMO D-SNP). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Amerivantage Full Dual Coordination (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. Amerivantage Full Dual Coordination (HMO D-SNP) is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid with your Medicare Part A and B cost sharing (deductibles, copayments and coinsurance), you may pay nothing for your Medicare health care services. Medicaid may also provide other benefits to you by covering health care services that are not usually covered under Medicare. Your coverage under TennCare provides coverage for Medicare premiums, deductibles and cost sharing applied to covered Medicare services and for additional Medicaid benefits as per state guidelines. You may also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. Amerivantage Full Dual Coordination (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Amerivantage Full Dual Coordination (HMO D-SNP) is run by a private company. Like all Medicare Advantage plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Tennessee Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

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.

Section 1.2

What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your Medicare medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan and how to file a complaint if you are not satisfied with a decision or treatment.

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of our plan.

It's important for you to learn what the plan's rules are and what services are available to you.

We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Service.

Section 1.3

Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)* and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in the plan between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Amerivantage Full Dual Coordination (HMO D-SNP) after December 31, 2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) and TennCare must approve our plan each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

Section 2. What makes you eligible to be a plan member?

Section 2.1

Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- *And* you live in our geographic service area (Section 2.3 describes our service area.) Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- *And* you are a United States citizen or are lawfully present in the United States.
- *And* you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and full Medicaid benefits including Long-term Care CHOICES benefits (for all members currently receiving CHOICES Group 1, 2 or 3). Your CHOICES must be covered with Amerigroup.

Please note: If you lose your Medicaid eligibility specifically related to long-term services and support (LTSS) CHOICES Group 1, 2 or 3 with Amerigroup but can reasonably be expected to regain eligibility within 90 days, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2

What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

Section 2.3

Here is the plan service area for Amerivantage Full Dual Coordination (HMO D-SNP)

Amerivantage Full Dual Coordination (HMO D-SNP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in TN: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2 Section 5 .

Section 2.4

U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Amerivantage Full Dual Coordination (HMO D-SNP) if you are not eligible to remain a member on this basis. Amerivantage Full Dual Coordination (HMO D-SNP) must disenroll you if you do not meet this requirement.

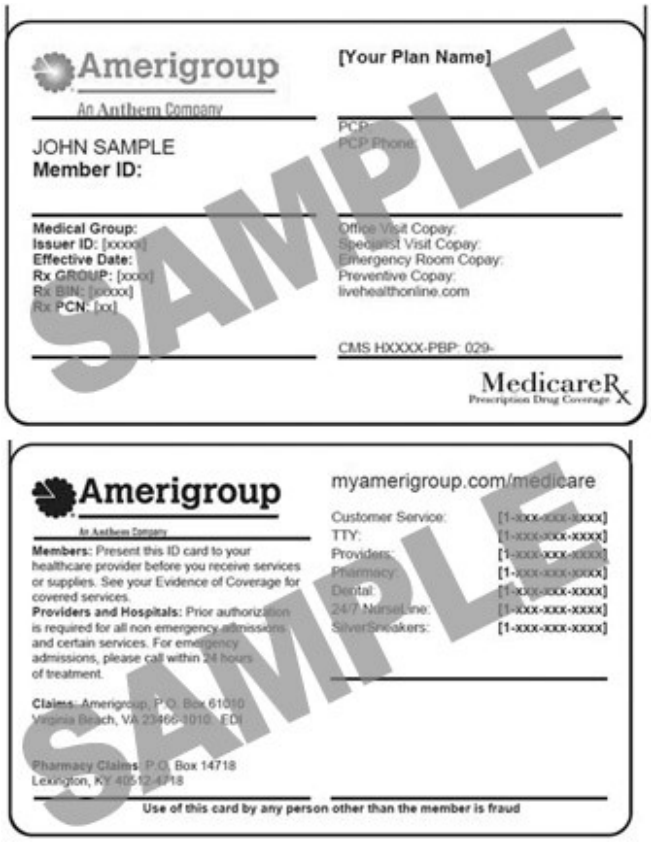
Section 3. Important membership materials you will receive

Section 3.1

Your plan membership card

While you are a member of our plan, you must use your Amerigroup member ID card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. IMPORTANT – If you have Medicare and TennCare (Medicaid), make sure to only show your Amerigroup member ID card and not your state Medicaid ID card whenever you access services. This will help your provider bill correctly.

Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Amerivantage Full Dual Coordination (HMO D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services or participate in Medicare-approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost or stolen, call Customer Service right away, and we will send you a new card.

Section 3.2

Provider/Pharmacy Directory

The *Provider/Pharmacy Directory* lists our network providers and durable medical equipment suppliers.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment, and any plan cost sharing, as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in network), out-of-area dialysis services and cases in which the plan authorizes use of out-of-network providers.

The *Provider/Pharmacy Directory* also lists our network pharmacies.

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the *Provider/Pharmacy Directory*, you can get a copy from Customer Service. You can also find this information on our website at www.amerigroup.com/medicare.

Section 3.3

The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "*Drug List*" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on

this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's *Drug List*.

The *Drug List* also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the *Drug List*. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.amerigroup.com/medicare) or call Customer Service.

Section 4. Your monthly cost for the plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B premium (Section 4.2)
- Part D late-enrollment penalty (Section 4.3
- Income-related monthly adjusted amount (Section 4.4)

Section 4.1

Plan premium

You do not pay a separate monthly plan premium for Amerivantage Full Dual Coordination (HMO D-SNP).

Section 4.2

Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most Amerivantage Full Dual Coordination (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A, which affects members who aren't eligible for premium-free Part A.

Section 4.3

Part D late-enrollment penalty

Because you are dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some members are required to pay a Part D **late-enrollment penalty**. The Part D late-enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late-enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in Amerivantage Full Dual Coordination (HMO D-SNP), we let you know the amount of the penalty. If you do not pay your Part D late-enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This

information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note**: The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is $32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $32.74, which equals $4.5836. This rounds to $4.60. This amount would be **added to the monthly premium for someone with a Part D late-enrollment penalty.**

There are three important things to note about this monthly Part D late-enrollment penalty:

- First, **the penalty may change each year,** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late-enrollment penalty will reset when you turn 65. After age 65, your Part D late-enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late-enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late-enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late-enrollment penalty.

Important: Do not stop paying your Part D late-enrollment penalty while you're waiting for a review of the decision about your late-enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4

Income-related monthly adjustment amount

Some members may be required to pay an extra charge, known as the Part D income-related monthly adjustment amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan

premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 5. More information about your monthly premium

Section 5.1

Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late-enrollment penalty, if owed. Or need to start paying a late-enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late-enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late-enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

Section 6. Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your primary care provider.

The doctors, hospitals, pharmacists and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes

- ☐ Changes to your name, your address or your phone number
- ☐ Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation or Medicaid)
- ☐ If you have any liability claims, such as claims from an automobile accident
- ☐ If you have been admitted to a nursing home
- ☐ If you receive care in an out-of-area or out-of-network hospital or emergency room
- ☐ If your designated responsible party (such as a caregiver) changes
- ☐ If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so.)

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2 Section 5 .

Section 7. How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability or end-stage renal disease (ESRD):
  - If you’re under 65 and disabled, and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you’re over 65, and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers’ compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

Chapter 2

Important phone numbers and resources

Section 1. Our plan's contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing or membership card questions, please call or write to our plan's Customer Service. We will be happy to help you.

Customer Service – contact information

Call:	1-833-713-1074. Calls to this number are free. From October 1 through March 31, Customer Service representatives will be available to answer your call directly from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. From April 1 through September 30, Customer Service representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays. Our automated system is available any time for self-service options. You can also leave a message after hours and on weekends and holidays. Please leave your phone number and the other information requested by our automated system. A representative will return your call by the end of the next business day. Customer Service also has free language interpreter services available for non-English speakers.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
Fax:	1-877-664-1504
Write:	Amerigroup Customer Service P.O. Box 62947 Virginia Beach, VA 23466-2947
Website:	https://shop.amerigroup.com/medicare

How to contact us when you are asking for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 8 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Coverage decisions medical care – contact information

Call:	1-833-713-1074. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Coverage decisions medical care – contact information

Fax: 1-877-664-1504

Write: Amerigroup Coverage Determinations
P.O. Box 62947
Virginia Beach, VA 23466-2947

Website: https://shop.amerigroup.com/medicare

Coverage decisions for Part D prescription drugs— contact information

Call: 1-833-498-1587. Calls to this number are free. Hours are 24 hours a day, seven days a week.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 24 hours a day, seven days a week.

Fax: 1-844-521-6938

Write: Amerigroup
Attention: Pharmacy Department
P.O. Box 47686
San Antonio, TX 78265-8686

Website: https://shop.amerigroup.com/medicare

Appeals for medical care – contact information

Call: 1-833-713-1074. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Fax: 1-888-458-1406

Write: Medicare Complaints, Appeals & Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Website: https://shop.amerigroup.com/medicare

Appeals for Part D prescription drugs – contact information

Call: 1-833-498-1587. Calls to this number are free. Hours are 24 hours a day, seven days a week.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 24 hours a day, seven days a week.

Fax: 1-888-458-1407

Write: Medicare Complaints, Appeals & Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Website: https://shop.amerigroup.com/medicare

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 8 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Complaints about medical care – contact information

Call:	1-833-713-1074. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Fax:	1-888-458-1406
Write:	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Medicare Website:	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Complaints about Part D prescription drugs – contact information

Call:	1-833-498-1587. Calls to this number are free. Hours are 24 hours a day, seven days a week.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 24 hours a day, seven days a week.
Write:	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Medicare Website:	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 6 *(Asking us to pay a bill you have received for covered medical services or drugs.)*

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 8 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Payment requests for medical care – contact information

Call: 1-833-713-1074. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Write: Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

Website: www.amerigroup.com/medicare

Payment requests for Part D prescription drugs - contact information

Call: 1-833-498-1587. Calls to this number are free. Hours are 24 hours a day, 7 days a week.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Write: CarelonRx
Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

Website: www.amerigroup.com/medicare

Section 2. Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations, including us.

Medicare – contact information

Call: **1-800-MEDICARE,** or **1-800-633-4227**
Calls to this number are free, 24 hours a day, seven days a week.

TTY: 1-877-486-2048
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Website: https://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provide Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about our plan.

- **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/Home.aspx**.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at **1-800-MEDICARE 1-800-633-4227,** 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.)

Section 3. State Health Insurance Assistance Program (free help, information and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The SHIP for your state is listed below.

SHIPs are independent (not connected with any insurance company or health plan). They are state programs that get money from the federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on **"Talk to Someone"** in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

In Tennessee:

TN SHIP – contact information

Call: 1-877-801-0044

TTY: 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: TN SHIP
500 Deaderick Street
Suite 825
Nashville, TN 37243-0860
Website: http://www.tnmedicarehelp.com/

Write: KEPRO - Region 4
5201 West Kennedy Boulevard
Suite 900
Tampa, FL 33609
Website: http://www.keproqio.com/default.aspx

Section 4. Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. *The Quality Improvement Organization for your state is listed below.*

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization in your state in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

In Tennessee:
KEPRO - Region 4 – contact information
Call: 1-888-317-0751 Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
TTY: 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Section 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or end-stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Social Security - contact information
Call: 1-800-772-1213
Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY: 1-800-325-0778
This number requires special telephone equipment and is only

for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.

Website: https://www.ssa.gov

Section 6. Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Helps pay Part B premiums. Eligible beneficiaries are also eligible for full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** An individual who is not QMB or SLMB, but is eligible for full Medicaid benefits either categorically or through optional coverage groups.

If you have questions about the assistance you get from Medicaid, contact TennCare.

In Tennessee:

TennCare – contact information

Call: 1-800-342-3145 8:00 a.m. - 5:00 p.m. Monday through Friday

TTY: 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: TennCare
310 Great Circle Road
Nashville, TN 37243

Website: https://www.tn.gov/tenncare

The State Long-Term Care Ombudsman helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

State Long-Term Care Ombudsman – contact information

Call: 1-615-741-2056.8:00 a.m. - 4:30 p.m. CT M-F

TTY: 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: State Long-Term Care Ombudsman
502 Deaderick Street
9th Floor
Nashville, TN 37243-0860

Website: https://www.tn.gov/aging

The State Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

State Long-Term Care Ombudsman – contact information

Call: 1-877-236-0013.8:00 a.m. to 4:00 p.m. CT Monday through Friday

TTY: 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: State Long-Term Care Ombudsman
502 Deaderick Street
9th Floor
Nashville, TN 37243-0860

Website: https://www.tn.gov/aging/our-programs/long-term-care-ombudsman.html

Section 7. Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" program

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this "Extra Help."

If you have questions about "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, seven days a week;
- The Social Security Office at 1-800-772-1213, between 8 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or if you already have the evidence, to provide this evidence to us.

Please fax or mail a copy of your paperwork showing you qualify for a subsidy using the fax number or address shown on the back cover of this booklet. Below are examples of the paperwork you can provide:

- A copy of your Medicaid card if it includes your eligibility date during the discrepant period;
- A copy of a letter from the state or SSA showing Medicare Low-Income Subsidy status;
- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A screen print from the state's Medicaid systems showing Medicaid status during the discrepant period;
- Evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point-of-sale.

If you have been a resident of a long-term-care facility (like a nursing home), instead of providing one of the items above, you should provide one of the items listed below. If you do, you may be eligible for the highest level of subsidy.

- A remittance from the facility showing Medicaid payment for a full calendar month for you during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on your behalf; or
- A screen print from the state's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

Once we have received your paperwork and verified your status, we will call you so you can begin filling your prescriptions at the low-income copayment.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying

your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance.

Note: To be eligible for the ADAP operating in your State, 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.
If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

In Tennessee:
Ryan White Program – contact information

Call: 1-615-741-7500

TTY: 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: Ryan White Program
710 James Robertson Parkway
Nashville, TN 37243

Website: http://tn.gov/health

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

In Tennessee:
A full-service SPAP is not available in this state.

Section 8. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board – contact information

Call: 1-877-772-5772
Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.

TTY: 1-312-751-4701
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.

Website: rrb.gov

Chapter 3

Using the plan for your medical and other covered services

Section 1. Things to know about getting your medical care and other services as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 *(Medical Benefits chart (what is covered))*.

Section 1.1

What are "network providers" and "covered services"?

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network Providers"** are the doctors and other health care professionals, medical groups, hospitals and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **"Covered Services"** include all the medical care, health care services, supplies, equipment and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2

Basic rules for getting your medical care and other services covered by the plan

As a Medicare and Medicaid health plan, our plan must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare. Please see the Medical Benefits Chart in Chapter 4.

The plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP. (For more information about this, see Section 2.1 in this chapter.)
- You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. Here are three exceptions:
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare or Medicaid requires our plan to cover but

there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in network. You should obtain authorization from the plan prior to seeking care. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

– The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

Section 2. Use providers in the plan's network to get your medical care and other services

Section 2.1

You must choose a primary care provider (PCP) to provide and oversee your care

What is a "PCP" and what does the PCP do for you?

When you join our plan, you will choose a plan provider to be your primary care provider (PCP). Your PCP is a physician, nurse practitioner or physician assistant who meets state requirements and is trained to give you basic medical care. If you do not have a PCP at the time you join, a plan representative can help you select one. If you are not able to choose a PCP, we will assign you to a contracted PCP with a convenient office location based on your home address.

PCPs can be any of the following kinds of doctors as long as they are in our plan's network:

- General practitioners
- Family practitioners
- Internal Medicine doctors
- Pediatricians
- Geriatrics

As we explain below, you can get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you get as a plan member.

You will see your PCP for most of your routine health care needs.

Your PCP may provide most of your care and may help arrange or coordinate the rest of the covered services you get as a plan member. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions and follow-up care. Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP can help arrange your care. In some cases, your PCP will need to get prior authorization (prior approval). Since your PCP may provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

Your PCP is available to coordinate your care with specialists and other providers. If one of your providers orders a service that requires an authorization, the ordering provider is responsible for obtaining a prior authorization from our plan.

How do you choose your PCP?

You chose a PCP when you completed your enrollment form.

If you did not choose a PCP, we will select one for you who is located close to where you live. Your PCP's name and phone number will be printed on your membership card.

To select a new PCP, you may refer to the *Provider/Pharmacy Directory* you received, the *Provider/Pharmacy Directory* on our website, or call the Customer Service phone number on the back cover of this booklet. To help you make your selection, our online provider search allows you to choose providers near you and gives information about the doctor's gender, language, hospital affiliations and board certifications.

Customer Service also can help you choose a doctor. If you are already seeing a doctor, you can look in the *Provider/Pharmacy Directory* to see if that doctor is in our network. If so, you can tell us you want to keep that doctor.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

If you want to change your PCP, and you need help finding a network provider, please call Customer Service at the number shown on the back cover of this booklet, or visit our website to access our online, searchable directory. If you would like a *Provider/Pharmacy Directory* mailed to you, you may call Customer Service, or request one on our website.

Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure the PCP you want to switch to is able to accept new patients.

Customer Service will change your membership record to show the name of your new PCP and tell you when the change to your PCP will take effect. Once your PCP has been changed, you will get a new membership card in the mail within 10 working days.

Section 2.2

What kinds of medical care and other services can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests and pelvic exams, as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible, or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- This plan does not require referrals from your PCP or any network providers
- Covered preventive services; see Chapter 4, Medical Benefits Chart.

Section 2.3

How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body.

There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint or muscle conditions.

For certain services provided by specialists, either your PCP or specialist will need to get prior approval from us. This is called getting "prior authorization." (For more information about this, see the Medical Benefits Chart in Chapter 4.) When we give our decision, we base it on two things. First there are Medicare's and the state Medicaid program's rules. Second, there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for urgent care, emergency care or renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Customer Service. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. You should obtain authorization from the plan prior to seeking care.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 8.

Section 2.4

How to get care from out-of-network providers

This plan does not provide coverage for services received from out-of-network providers, except emergency, urgently needed care and end-stage renal disease services. You are not responsible for obtaining authorization for emergency, urgently needed care or end-stage renal disease services received from out-of-network providers.

Section 3. How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1

Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help, or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at the number on the back of your plan membership card.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- *Or*, the additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care. (For more information about this, see Section 3.2 below.)

Section 3.2

Getting care when you have an urgent need for services

What are "urgently needed services"?

An urgently needed service is a nonemergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare up of a known condition when you are temporarily outside the service area.

You can receive care from any urgent care provider included in your *Provider/Pharmacy Directory*. If you are having trouble finding an urgent care provider, please call Customer Service.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: if you're traveling outside of the United States for less than six months. Prescriptions purchased outside of the country are not covered even for urgent or emergency care. For more information, please see the Medical Benefits Chart in Chapter 4 of this booklet.

Section 3.3

Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: https://shop.amerigroup.com/medicare for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

Section 4. What if you are billed directly for the full cost of your services?

Section 4.1

You can ask us to pay for covered services

If you have paid for covered services, or if you have received a bill for covered medical services, go to Chapter 6 *(Asking us to pay a bill you have received for covered medical services or drugs)* for information about what to do.

Section 4.2

What should you do if services are not covered by our plan?

The plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services. Before paying for the cost of the service, members should check if the service is covered by Medicaid.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. When the benefit limit has been reached, the costs you pay do not count toward your out-of-pocket maximum.

Section 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1

What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Section 5.2

When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in a clinical research study.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Section 6. Rules for getting care in a "religious nonmedical health care institution"

Section 6.1

What is a religious nonmedical health care institution?

A religious nonmedical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility.

If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious nonmedical health care institution.

This benefit is provided only for Part A inpatient services (nonmedical health care services).

Section 6.2

Receiving care from a religious nonmedical health care institution

To get care from a religious nonmedical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "nonexcepted."

- "Nonexcepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state or local law.

To be covered by our plan, the care you get from a religious nonmedical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *nonreligious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - *And* you must get approval in advance from our plan, before you are admitted to the facility, or your stay will not be covered.

The Medicare inpatient hospital coverage limits apply to care received in a religious nonmedical health care institution. For more information, see the Medical Benefits Chart in Chapter 4.

Your coverage under Medicaid may provide additional coverage or benefits.

Section 7. Rules for ownership of durable medical equipment

Section 7.1

Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating

devices, IV infusion pumps, nebulizers and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent, including oxygen equipment.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you usually will acquire ownership of the DME items following a rental period not to exceed 13 months from an in-network provider or 13 months rental from a nonnetwork provider. Your copayments will end when you obtain ownership of the item. Oxygen-related equipment rental is 36 months before ownership transfers to you.

What happens to payments you have made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2

Rules for oxygen equipment, supplies and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Amerivantage Full Dual Coordination (HMO D-SNP) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Amerivantage Full Dual Coordination (HMO D-SNP) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

Chapter 4

Medical Benefits Chart (What is covered)

Section 1. Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1

You pay nothing for your covered services

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plans' rules for getting your care. See Chapter 3 for more information about the plans' rules for getting your care.

Grace period
If you lose your TennCare (Medicaid) CHOICES Group 1, 2, or 3 with Amerigroup eligibility, you can remain enrolled in this Medicare plan for 90 days. You must re-enroll in Medicaid before the end of the 90-day period to keep your Medicare and Medicaid CHOICES benefits with this plan. During the 90-day period, if you do go to your provider, you will have out-of-pocket costs that your Medicare plan will not cover, you will be responsible for those costs until you regain your Medicaid CHOICES eligibility. Your out-of-pocket costs may include Medicare plan deductibles, copayments and coinsurance up to the Original Medicare amounts, which can be found at www.medicare.gov. In addition, you will need to pay the plan premium previously covered by TennCare (Medicaid) CHOICES. If you receive services during this time, you will be responsible for up to $7,550 for applicable Medicare-covered services. Please call Customer Service (phone numbers are printed on the back cover of this booklet) for additional information related to out-of-pocket costs during the grace period.
If you do not re-enroll in TennCare (Medicaid) CHOICES Group 1, 2, or 3 with Amerigroup during the 90 days, you will be disenrolled from our plan. You will be enrolled in Original Medicare.

Section 1.2

What is the most you will pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. 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.

Because you are enrolled in a Medicare Advantage plan, there is a limit on the amount you have to pay out of pocket each year for medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket amount for medical services. For calendar year 2023, this amount is $8,300.00.

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.) If you reach the maximum out-of-pocket amount of $8,300.00, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 2. Use the Medical Benefits Chart to find out what is covered for you

Section 2.1

Your medical benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services the plan covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare- and Medicaid-covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, equipment and Part B prescription drugs) must be medically necessary. "Medically necessary" means that the services, supplies or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked with a note in the Medical Benefits Chart. When we give our decision, we base it on two things. First there are Medicare's and the state Medicaid program's rules. Second there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost-effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for urgent care, emergency care or renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Customer Service. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including hospital and doctor visits. Medicaid also covers services Medicare does not cover, like home- and community-based services or other Medicaid-only services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- As a member of our plan, you have benefits under the Medicare and Medicaid parts of your coverage. You receive and pay nothing for these benefits whether they are Medicare or Medicaid benefits.
- If you are within our plan's three-month period of deemed continued eligibility, we will continue to provide all Medicare

Advantage plan-covered Medicare benefits. However, during this period, we will not cover Medicaid benefits that are included under the Medicaid state plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

Medicare approved Amerigroup to provide these benefits and/or lower copayments/coinsurance as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

Important benefit information for all enrollees participating in Wellness and Health Care Planning (WHP) services

- Because Amerivantage Full Dual Coordination (HMO D-SNP) participates in certain Value-Based Insurance Design benefits (benefits are marked in the Medical Benefits Chart by a footnote), you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - As a Amerivantage Full Dual Coordination (HMO D-SNP) member, you have access to an online advance care planning resource called, MyDirectives®. This resource helps you to create an advance directive where you can combine the elements of a:
    - Living will– decisions on what medical treatments you would or would not like to receive
    - Medical power of attorney – designation of one or more healthcare agents who can make medical decisions for you if you are not able to
    - Organ donation form
    - And more, including religious preference statements
  - You can create a new digital care plan on MyDirectives® or, if you already have these documents prepared, you can upload them so that they can be more easily shared with those that may need access to it. MyDirectives® is available to you and your designated medical providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change.
  - To get started, log into your Amerivantage Full Dual Coordination (HMO D-SNP) member portal and go to the Programs Dashboard and select Advance Directive Programs. It will take you to MyDirectives® to create a new account, or link your existing account.
  - Participation in any programs that include Wellness and Healthcare Planning or Advance Care Planning are voluntary and you are free to decline the services at any time.

Important benefit information for enrollees who qualify for “Extra Help”:

- Because you receive “Extra Help” to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you are eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- **Members in this plan will pay nothing for their Part D covered drugs through the deductible, initial coverage, gap coverage and catastrophic stages.**

Please refer to the below Medical Benefits Chart for further detail.

Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost-sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Additional information for people with Medicare and TennCare (Medicaid)

People who qualify for Medicare and TennCare (Medicaid) are known as dual eligibles. If you are a dual eligible, you are eligible for benefits under both the Federal Medicare program and TennCare. Amerigroup members must be eligible for Medicare cost-sharing assistance under Medicaid and meet other requirements. There are additional TennCare benefits that may be available to you as an Amerivantage Full Dual Coordination (HMO D-SNP) member. The benefit is noted in the chart if it is a TennCare benefit and not a Medicare benefit.

If you have any questions, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Benefit Packages

Not everyone in TennCare has the same benefits. The benefits that are covered for you depend on the group you're in. These are the TennCare groups and a short description:
A – Child under age 21
B – Over age 21
C – Over age 21 (TennCare Standard)
D – Over age 21 and is enrolled in Standard Spend Down
E – Over age 21 and enrolled in a home- and community-based services (HCBS) waiver for persons with intellectual disabilities
F – Over age 21 who also has Medicare
G – Over age 21, enrolled in a home- and community-based services (HCBS) waiver for persons with intellectual disabilities, and has Medicare
H – Child under age 21 who also has Medicare
J – Over age 21 and is enrolled in TennCare CHOICES Group 1 or Group 2 and does not have Medicare
K – Over age 21, enrolled in TennCare CHOICES Group 1 or Group 2, and has Medicare
L – Over age 21, enrolled in TennCare CHOICES Group 3 and does not have Medicare
M – Over age 21, enrolled in TennCare CHOICES Group 3, and has Medicare

 **You will see this apple next to the preventive services in the benefits chart.**

Medical benefits chart

For in-network services (in our plan): All services must be coordinated by your primary care provider (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more.

You may have more than one cost share to pay if you get more than one service at a visit. Cost share amounts for services are listed in this chart below.

If you also are treated for another condition during a preventive service visit, or if other services are billed with the preventive service, the cost sharing for the other services will also apply. Medicare preventive services are shown with an apple in this chart.

Services That Are Covered for You	What You Must Pay When You Get These Services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: ▪ lasting 12 weeks or longer; ▪ nonspecific, in that is has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); ▪ not associated with surgery; and ▪ not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.	**In-network:** **$0.00** copay for each Medicare-covered acupuncture visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: ▪ a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, ▪ a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Prior authorization may be required.	
Advance Directives Program **MyDirectives**[1] ▪ Documenting what's important to you is essential to getting the care you want when you are too ill to speak for yourself. ▪ As a Amerivantage Full Dual Coordination (HMO D-SNP) member, you have access to an online advance care planning resource called, MyDirectives®. This resource helps you to create an advance directive where you can combine the elements of a: ▪ Living will - decisions on what medical	**$0.00** copay for the Advance Directives Program.

Services That Are Covered for You	What You Must Pay When You Get These Services
treatments you would or would not like to receive ▪ Medical power of attorney - designation of one or more healthcare agents who can make medical decisions for you if you are not able to ▪ Organ donation form ▪ And more, including religious preferences statements ▪ You can create a new digital care plan on MyDirectives® or, if you already have these documents prepared, you can upload them so that they can be more easily shared with those that may need access to it. MyDirectives® is available to you and your designated medical providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change. ▪ To get started, log into your Amerivantage Full Dual Coordination (HMO D-SNP) member portal at https://shop.amerigroup.com/medicare. Select "My Plans" from the top menu, then select "Medical" and this will take you to your medical benefits, where you can scroll down to Advance Directive Programs. The link in the benefit detail will take you to MyDirectives® to create a new account, or link your existing account. ▪ Participation in any programs that include Wellness and Healthcare Planning or Advance Care Planning are voluntary and you are free to decline the services at any time. [1]Value Based Insurance Design benefit	

Services That Are Covered for You	What You Must Pay When You Get These Services
Ambulance services ▪ Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. ▪ Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Prior authorization may be required.	**$0.00** copay for each covered, one-way ambulance trip by ground or water. **$0.00** copay for each covered, one-way air ambulance trip. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Annual routine physical exam In addition to the "Welcome to Medicare" exam or the annual wellness visit, you are covered for one routine physical exam each year. The routine physical includes a comprehensive examination and evaluation of your health status and chronic diseases. Please note: Additional cost share may apply for additional services or testing performed during your visit as described for each service in this medical chart.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for one routine physical exam each calendar year. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based	**In-network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Breast cancer screening (mammograms) Covered services include: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women aged 40 and older ▪ Clinical breast exams once every 24 months	**In-network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a	**In-network:** **$0.00** copay for each covered therapy visit to treat you if you've had a heart condition.

Services That Are Covered for You	What You Must Pay When You Get These Services
doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Prior authorization may be required.	Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Cervical and vaginal cancer screening Covered services include: ▪ For all women: Pap tests and pelvic exams are covered once every 24 months ▪ If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Chiropractic services Covered services include: ▪ Manual manipulation of the spine to correct subluxation Additional covered supplemental chiropractic benefits include: ▪ 48 visits each year for routine chiropractic services. Prior authorization may required.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for each Medicare-covered visit to see a chiropractor. **$0.00** copay for routine chiropractic visits. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Colorectal cancer screening For people 50 and older, the following are covered: ▪ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: ▪ Guaiac-based fecal occult blood test (gFOBT) ▪ Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years. For people at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy (or screening barium enema as an alternative) every 24 months ▪ Includes the biopsy and removal of any growth during a colonoscopy, in the event the procedure goes beyond a screening exam For people not at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	**In-network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **$0.00** copay for a biopsy or removal of tissue during a screening exam of the colon. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Dental services - Medicare-covered In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Prior authorization may be required.	**In-network:** For in-network Medicare-covered dental benefits, you must use a provider that is part of the Amerivantage Full Dual Coordination (HMO D-SNP) medical network. You can find these providers in the Provider/Pharmacy Directory. To learn more, call the Customer Service number on the back cover of this document. **$0.00** copay for Medicare-covered dental services. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Dental services - Supplemental This plan provides additional dental coverage not covered by Original Medicare. This plan covers: 2 oral exam(s), 2 cleaning(s), 1 dental X-ray(s), 1 fluoride treatment(s) every year. The above preventive dental services are limited to the following: ▪ D0120 Periodic oral evaluation ▪ D0150 Comprehensive oral evaluation ▪ D1110 Prophylaxis, adult ▪ D0210 Intraoral, complete series of radiographic images ▪ D0330 Panoramic radiographic image ▪ D1208 Topical application of fluoride, excluding varnish This plan covers up to a **$5,000.00** allowance for covered comprehensive dental services every year.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** To be covered in-network, you need to use a provider that is contracted with our dental vendor to provide supplemental dental services. Care rendered by a provider that is not part of our supplemental dental network is not covered. After plan paid benefits for comprehensive dental services, you are responsible for the remaining costs. **$0.00** copay for covered preventive dental services designed to help prevent disease. **$0.00** copay for comprehensive dental services up to your allowance amount. Any amount not used at the end of the calendar year will expire.

Services That Are Covered for You	What You Must Pay When You Get These Services
Our comprehensive dental allowance can be used toward covered dental service, including but not restricted to: ▪ Additional exams, cleanings and x-rays, deep teeth cleanings, fluoride treatments, fillings and repairs, root canals (Endodontics), dental crowns (Caps), bridges and implants, dentures, extractions and other services. Prior authorization may be required.	Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: ▪ Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. ▪ For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. ▪ Diabetes self-management training is covered under certain conditions. This plan covers only OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will NOT be covered. Lancets are limited to the following manufacturers: LifeScan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King	**In-network:** This plan covers one blood glucose monitor every calendar year. OneTouch® Test Strips are covered for 100 units every 30 days and up to 300 units for a 90 day supply. ACCU-CHECK® Test Strips are covered for 102 units every 30 days and up to 306 units for a 90 day supply. Lancets are covered for 100 units every 30 days and up to 300 units for a 90 day supply. **$0.00** copay for: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Blood glucose monitors **$0.00** copay for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a Durable Medical Equipment (DME) provider. **$0.00** copay for covered charges for training to help you learn how to monitor your diabetes. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor. If you are using a brand of diabetic test strips or lancets that is not covered by our plan, we will continue to cover it for up to two fills during the first 90 days after joining our plan. The meter will only be filled once during the transition period. This 90 day transitional coverage is limited to once per lifetime. During this time, talk with your doctor to decide what brand is medically best for you. Your provider must get an approval from the plan before we'll pay for test strips or lancets greater than the amount listed above or are not from the approved manufacturers.	
Durable medical equipment (DME) and related supplies (For a definition of “durable medical equipment,” see Chapter 11 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.	**In-network:** **$0.00** copay for covered durable medical equipment. Your provider must get our approval for items such as powered vehicles, powered wheelchairs and related items, and wheelchairs and beds that are not standard. Your provider must also get approval for therapeutic continuous glucose monitors covered by Medicare. Medicare oxygen equipment: **$0.00** copay

Services That Are Covered for You	What You Must Pay When You Get These Services
We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website located on the back cover of this document. If you receive a durable medical equipment item during an inpatient stay in a hospital or skilled nursing facility, the cost will be included in your inpatient claim. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will not be covered. Coverage limitations: ▪ 2 Sensors per month ▪ One receiver every 2 years Insulin pumps are different than a CGM and can	Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in Amerivantage Full Dual Coordination (HMO D-SNP) you had made 36 months of rental payments for oxygen equipment coverage, your cost sharing in Amerivantage Full Dual Coordination (HMO D-SNP) is **$0.00** copay You must get durable medical equipment through our approved suppliers. You cannot purchase these items from a pharmacy. **$0.00** copay for CGMs and related supplies. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
be purchased through a DME provider. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids. We will not cover other brands unless your provider tells us it is medically necessary. Prior authorization may be required.	
Emergency care Emergency care refers to services that are: ▪ Furnished by a provider qualified to furnish emergency services, and ▪ Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Emergency care coverage is worldwide.	**$0.00** copay for each emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. Your emergency room copay will be waived if you receive care from a primary care provider, urgent care provider, or LiveHealth Online within 24 hours prior to the emergency room visit. This plan covers emergency services if you're traveling outside of the United States for less than six months. Coverage is limited to **$100,000** per year for worldwide emergency services. This is a supplemental benefit. It's not covered by the Federal Medicare program. You must pay all costs over **$100,000** and all costs to return to your service area. You may be able to buy added travel insurance through an authorized agency.

Services That Are Covered for You	What You Must Pay When You Get These Services
	$0.00 copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Everyday Extras You may choose only one (1) of the supplemental benefits below. You can select your benefit(s) either via the member portal or by contacting Customer Service. For the benefit(s) to be covered, you must use an approved provider and meet any precertification criteria. You may be able to make a one- (1-) time change to your initial election if you have not used any part of your benefit(s). You will receive a confirmation letter within 7 business days of your election(s) with benefit(s) details. If you have any questions, please contact Customer Service. The phone number is listed on the back of this document. **Assistive Devices**[1]**:** This benefit provides an annual spending allowance toward the purchase of assistive devices on your Benefits Prepaid Card. Covered items allowed by Medicare include, but are not limited to: ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair ramps, and more. The card is prepaid by the plan with the spending allowance amount. You can only pay for your own services and cannot convert the	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** If selecting one (1) of these **Everyday Extras:** ▪ Assistive Devices: **$500** every year ▪ Flex Account - Dental, Vision, Hearing: **$500** every year ▪ Flex Account - Utilities: **$50** every month ▪ In-Home Support: 60 hours every year ▪ Transportation: 60 one-way trips every year You pay nothing for the one (1) Everyday Extras supplemental benefit option you have chosen. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
card to cash. Any unused funds will expire at the end of the year and cannot be rolled over into the following year. To place an order for home delivery: ▪ Go online ▪ Call to place an order. Pick items by going online or from the Assistive Device catalog. **Note:** ▪ Once you've used your annual spending allowance amount, you are responsible for the remaining cost of your purchases. ▪ Any repair or replacement of items selected is limited to the manufacturer's warranty. ▪ Items must be for your use only. ▪ Items are limited to those offered within the catalog and online through our vendor and are subject to availability. ▪ Quantity limits may apply. ▪ Installation services are not included. [1]Value Based Insurance Design benefit **Flex Account - Dental, Vision, Hearing[1]:** The Flex Account - Dental, Vision, Hearing benefit provides an annual spending allowance on your Benefits Prepaid Card that may be used to reduce your out-of-pocket expenses for any dental, vision, and/or hearing services as described in those sections of this chart. The card may be used to pay your dental, vision, or hearing provider directly for any out-of-pocket expenses you incur. The card is prepaid by the plan with the spending allowance. You can only pay for your	

Services That Are Covered for You	What You Must Pay When You Get These Services
own services and cannot convert the card to cash. Cosmetic procedures are not covered under this benefit. Any unused funds will expire at the end of the year and cannot be rolled over into the following year. If your provider does not accept a prepaid card for payment or in the event of a card transaction failure, you may submit a claim form for reimbursement along with the original printed, itemized receipt from the provider. Claims must be submitted within 90 days of the date of service on your receipt. [1]Value Based Insurance Design benefit **Flex Account - Utilities[1]:** Flex Account – Utilities provides a spending allowance on your Benefits Prepaid Card that may be used to reduce your out-of-pocket expenses for household utilities such as natural/propane gas, electric, water, or sewer. It can also be used with internet and cellular providers. The card may be used to cover these expenses when provided by any utility provider that accepts a prepaid card. The card is prepaid by the plan with the spending allowance amount. You can only pay for your own services and cannot convert the card to cash. The card cannot be used to set up automated recurring transactions. Any unused funds will expire at the end of the month and cannot be rolled over into the following month. If your provider does not accept a prepaid card for payment or in the event of a card transaction	

Services That Are Covered for You	What You Must Pay When You Get These Services
failure, you may submit a claim form for reimbursement along with proof of payment. Claims must be submitted within 90 days of the date of payment. **Note:** This benefit can only be used towards your personal expenses and not anyone else's. [1]Value Based Insurance Design benefit **In-Home Support**[1]**:** This benefit provides companionship and assistance with independent activities of daily living such as home-based chores, help getting to appointments or getting items such as groceries, medication, and more. Help getting to appointments does not include transportation. In-home support can work in conjunction with other benefits or care plans to promote independent living, aid in reducing a member's feeling of social isolation, and improve their overall mental outlook. You must use the plan approved provider. [1]Value Based Insurance Design benefit **Transportation**[1]**:** This benefit covers one-way trips (60-mile limit per one-way trip) to locations within the local service area when obtaining plan-covered services. Trips may be covered for getting to and from medical visits, SilverSneakers locations, and visits to a pharmacy to pick up prescriptions.	

Services That Are Covered for You	What You Must Pay When You Get These Services
Stops at a pharmacy after a covered medical service will not count as a separate trip. You must use the plan approved vendor and schedule trips 48 hours (excluding weekends) in advance. [1]Value Based Insurance Design benefit	
Health & fitness tracker Coverage includes a fitness tracking device to track your physical activity and access to online tools designed to provide guidance and promote an active lifestyle. Limit is one device every two years provided through our contracted vendor. Please contact Customer Service for more information.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for health and fitness tracker. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Health and wellness education programs These programs are designed to enrich the health and lifestyles of members. ▪ 24-Hour Nurse HelpLine: As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. - see 24-Hour Nurse HelpLine for more details ▪ Personal Emergency Response System (PERS) - see Personal Emergency Response System for more details ▪ SilverSneakers® Fitness Program - see SilverSneakers for more details	**In-network:** Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for health and wellness programs covered by this plan. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Healthy Meals-Post Discharge After you are discharged from an inpatient stay at a hospital or skilled nursing facility, you may qualify for nutritious, precooked, frozen meals delivered to you at no cost. After an overnight stay at a hospital or skilled nursing facility, you may be contacted by the plan or one of its representatives, to see if you would like this benefit. Alternatively, you or your provider/case manager can contact Customer Service after your discharge and a representative will help validate that you qualify for the benefit and arrange for you to be contacted to complete a nutritional assessment and schedule delivery of your meals. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for up to 2 meals a day for 21 days following your discharge from the hospital or skilled nursing facility (SNF). Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Hearing services - Medicare-covered Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Prior authorization may be required.	**In-network:** For in-network Medicare-covered hearing care, you must use a doctor in the Amerivantage Full Dual Coordination (HMO D-SNP) specialty medical network. You can find them in the Provider/Pharmacy Directory. To learn more, call the Customer Service number on the back cover of this document. **$0.00** copay for each covered hearing evaluation to determine if you need medical treatment for a hearing condition.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Hearing services - Supplemental This plan provides additional hearing coverage not covered by Original Medicare. This plan covers 1 routine hearing exam(s) and hearing aid fitting/evaluation(s) every year. **$3,000.00** maximum plan benefit coverage amount applies to prescribed hearing aids covered by the plan every year. The Plan has negotiated rates and options through our hearing aid supplier to give you the most options. You must select a device from the covered list available through our participating hearing aid supplier. Hearing Aids may require prior authorization from our hearing supplier. If members choose a device with non rechargeable batteries, the plan will provide a 2-year supply (up to 64 cells per ear, per year). To learn more, call the Customer Service number on the back cover of this booklet. After plan paid benefits for routine hearing exams or hearing aids, you are responsible for the remaining cost. Prior authorization may be required.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. Hearing aids may require prior authorization from our hearing supplier to ensure you are fitted with the most appropriate device available under the plan. To find a provider affiliated with our hearing supplier or for information on covered devices, call the Customer Service number on the back cover of this document. **In-network:** **$0.00** copay for routine hearing exam(s). **$0.00** copay for hearing aids up to the maximum plan benefit amount. Hearing aids are limited to specific devices, based on your hearing needs. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: ▪ One screening exam every 12 months For women who are pregnant, we cover: ▪ Up to three screening exams during a pregnancy	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: ▪ Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies Prior authorization is required.	**In-network:** **$0** copay for each covered visit from a home health agency. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The	**In-network:** **$0.00** copay for Home Infusion Therapy (HIT) professional services furnished by a qualified HIT supplier in the patient's home.

Services That Are Covered for You	What You Must Pay When You Get These Services
components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters) Covered services include but are not limited to: ▪ Professional services, including nursing services, furnished in accordance with the plan of care ▪ Patient training and education not otherwise covered under the durable medical equipment benefits ▪ Remote monitoring ▪ Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the Home Infusion Therapy Professional Services, Home Infusion requires a Durable Medical Equipment component: ▪ Durable Medical Equipment - the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items Prior authorization may be required.	Durable medical equipment (DME): **$0.00** copay - includes the external infusion pump, the related supplies, and the infusion drug(s) by a contracted DME Provider. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.

Services That Are Covered for You	What You Must Pay When You Get These Services
You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: ▪ Drugs for symptom control and pain relief ▪ Short-term respite care ▪ Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). ▪ If you obtain the covered services from a network provider and follow the plan rules for	**In-network:** **$0** copay if you get a hospice consultation by a Primary Care Provider (PCP) before you elect hospice. **$0** copay if you get a hospice consultation by a specialist before you elect hospice. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
obtaining service, you only pay the plan cost-sharing amount for in-network services ▪ If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by our plan but are not covered by Medicare Part A or B: the plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 *(What if you're in Medicare-certified hospice)* **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Services That Are Covered for You	What You Must Pay When You Get These Services
Immunizations Covered Medicare Part B services include: ▪ Pneumonia vaccine ▪ A different, second pneumonia vaccine if received one year (or later) after the first vaccine is given. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. ▪ Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B ▪ COVID-19 vaccine ▪ Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	**In-network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. You can get a flu, pneumonia or COVID-19 vaccines without asking a doctor to refer you. The shingles shot is only covered under the Part D drug benefit. The shingles shot is not covered under the Part B drug benefit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. This plan covers the Medicare limit of 90 days per benefit period and 60 extra Lifetime Reserve days over your lifetime. Covered services include but are not limited to: ▪ Semi-private room (or a private room if	**In-network:** **$0.00** copay for covered hospital stays. A benefit period starts on the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't had any inpatient hospital care or skilled care in a SNF for 60 days in a row. This plan covers 90 days each benefit period. This plan pays for 60 extra days over your lifetime. You have no copay for these extra days.

Services That Are Covered for You	What You Must Pay When You Get These Services
medically necessary) ▪ Meals including special diets ▪ Regular nursing services ▪ Costs of special care units (such as intensive care or coronary care units) ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Necessary surgical and medical supplies ▪ Use of appliances, such as wheelchairs ▪ Operating and recovery room costs ▪ Physical, occupational, and speech language therapy ▪ Inpatient substance abuse services ▪ Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a distant location (outside of the service area) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and one	The hospital should tell the plan within one business day of any emergency admission. If you get inpatient care at an out-of-network hospital after your emergency condition is stable, your cost is the cost sharing you would pay at a network hospital. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient when required to be near the Medicare-approved transplant center to receive treatment/ services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Customer Service. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a	

Services That Are Covered for You	What You Must Pay When You Get These Services
claim, please go to Chapter 6, Section 2, How to ask us to pay you back or to pay a bill you have received. ▪ Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. ▪ Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not	**In-network:** **$0.00** copay for each covered hospital stay. Your provider must get an approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse or rehab. This is called getting prior authorization.

Services That Are Covered for You	What You Must Pay When You Get These Services
apply to inpatient Mental Health services provided in a psychiatric unit of a general hospital. Prior authorization may be required.	Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay This plan covers 90 days per benefit period and 60 extra lifetime reserve days over your lifetime for inpatient days and up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached this coverage limit, the plan will no longer cover your stay in the SNF. However, in some cases, we will cover certain services you receive while you are in the SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: ▪ Physician services ▪ Diagnostic tests (like lab tests) ▪ X-ray, radium, and isotope therapy including technician materials and services ▪ Surgical dressings ▪ Splints, casts and other devices used to reduce fractures and dislocations ▪ Prosthetics and orthotics devices (other than dental) that replace all or part of an internal	If you stay in a hospital or skilled nursing facility longer than what is covered, this plan will still pay the cost for doctors and other medical services that are covered as listed in this document. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices ▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition ▪ Physical therapy, speech therapy, and occupational therapy Prior authorization may be required.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Medicare Community Resource Support Need help with a specific issue? Although your plan benefits are designed to cover what	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.

Services That Are Covered for You	What You Must Pay When You Get These Services
Medicare would cover, as well as some additional supplemental benefits as described in this chart, you might need additional help. As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. The Medicare Community Resource Support team will assist you by providing information and education about community-based services and support programs in your area. To access this benefit, call Customer Service at the number listed on the back of your ID card and ask for the Medicare Community Resource Support team.	**In-network:** There is no additional cost for the assistance provided by the Medicare Community Resource Support team. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:	**In-network:** **$0.00** copay for chemotherapy and other drugs covered by Medicare Part B. Your provider must get an approval from the plan before you get certain injectable or

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit® and Aranesp®) ▪ Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Some of the Part B covered drugs listed above may be subject to step therapy. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://shop.amerigroup.com/medicare We also cover some vaccines under our Part B and Part D prescription drug benefit.	infusible drugs. Call the plan to learn which drugs apply. This is called getting prior authorization. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered.	
24-Hour Nurse HelpLine As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the 24-Hour Nurse HelpLine at 1-866-805-4589. TTY users should call 711.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for the Nurse HelpLine.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Opioid Treatment Program Services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: ▪ U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT)	**In-network:** **$0.00** copay for Opioid Treatment Program Services. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
medications ▪ Dispensing and administration of MAT medications (if applicable) ▪ Substance use counseling ▪ Individual and group therapy ▪ Toxicology testing ▪ Intake activities ▪ Periodic assessments Prior authorization may be required.	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: ▪ X-rays ▪ Radiation (radium and isotope) therapy including technician materials and supplies ▪ Surgical supplies, such as dressings ▪ Splints, casts and other devices used to reduce fractures and dislocations ▪ Laboratory tests ▪ Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. ▪ Other outpatient diagnostic tests Prior authorization may be required.	**In-network:** **$0.00** copay for each covered lab service. **$0.00** copay for hemoglobin A1c or urine tests to check albumin levels. **$0.00** copay for each covered diagnostic procedure or test. **$0.00** copay for tests to confirm chronic obstructive pulmonary disease (COPD). **$0.00** copay for each covered radiation therapy service. **$0.00** copay for each covered X-rays. **$0.00** copay for each covered diagnostic radiology service. **$0.00** copay for blood, blood storage, processing and handling services. **$0.00** copay for surgery bandages and supplies, such as casts and splints.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Your provider must get the plan's approval before you get complex imaging or some diagnostic, radiology therapy and lab services. These include radiation therapy, PET, CT, SPECT, MRI scans, heart tests called echocardiograms, lab tests, genetic tests, sleep studies and related supplies. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.	**In-network:** **$0.00** copay for observation room services you get at an outpatient hospital. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required.	
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ Laboratory and diagnostic tests billed by the hospital ▪ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it ▪ X-rays and other radiology services billed by the hospital ▪ Medical supplies such as splints and casts ▪ Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing	**In-network:** **$0.00** copay for outpatient hospital services such as: ▪ Covered surgery services ▪ Covered observation room services ▪ Medical supplies such as splints and casts **$0.00** copay for partial hospitalization for mental health or substance abuse. Additional information about other outpatient services can be found elsewhere in this benefit chart for emergency room visits, outpatient diagnostic tests and therapeutic services, and laboratory tests. Please see the Medicare Part B drugs section for details on certain drugs and biologicals. Look for the apple icon to learn about certain screenings and preventive care services. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Prior authorization may be required.	**In-network:** **$0.00** copay for each covered therapy visit. This applies to individual or group therapy. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital	**In-network:** **$0.00** copay for each covered physical, occupational and speech therapy visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization may be required.	
Outpatient substance abuse services Outpatient and ambulatory substance abuse treatment is supervised by an appropriate licensed professional. Outpatient treatment is provided for individuals or groups, and family therapy may be an additional component. Additional services may be covered in lieu of hospitalization, or as a step-down after hospitalization for substance abuse-related conditions. Prior authorization may be required.	**In-network:** **$0.00** copay for each covered therapy visit. This applies to individual or group therapy. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” Prior authorization may be required.	**In-network:** **$0.00** copay for each covered surgery or observation room service in an outpatient hospital. **$0.00** copay for each covered surgery in an ambulatory surgical center. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Over the Counter (OTC) + Healthy Groceries OTC + Healthy Groceries[1] provides you with a monthly spending allowance toward the purchase of Over-the-Counter (OTC) and healthy food items using your Benefits Prepaid Card at participating stores and online. Some items, such as tobacco and alcohol products, are excluded. OTC items are drugs and health related products that do not need a prescription and include: toothpaste, eye drops, nasal spray, vitamins, cough drops, pain relievers, antacids, first aid items, and more. Unused spending allowance amounts do not roll over to the following month or calendar year. Here are the ways you can use your benefit: ▪ Shop at participating stores near you. ▪ Shop online or call to place an order and have items delivered to your home. Pick items by going online or from the OTC catalog. **Note:** ▪ All purchases must be placed through the plan's approved retailers ▪ Once you reach your monthly spending allowance, you are responsible for the remaining cost of your purchases ▪ Orders delivered through the mail are limited to one order per month and must be for at least **$35** [1]Value Based Insurance Design benefit	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** Up to **$215.00** allowance for OTC items and Healthy Groceries each month. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting. Prior authorization may be required.	**In-network:** **$0.00** copay for each covered partial hospitalization visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Personal Emergency Response System (PERS) Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the Plan with a contracted vendor. The Personal Emergency Response System benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). Please call Customer Service for more information or to request the unit.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for one personal emergency response system and monthly monitoring by a contracted vendor. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Physician/Practitioner services, including doctor's office visits Covered services include: ▪ Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital	**In-network:** **$0.00** copay for each covered Primary Care Provider (PCP) office visit. **$0.00** copay for each covered specialist office visit.

Services That Are Covered for You	What You Must Pay When You Get These Services
outpatient department, or any other location ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment ▪ Certain telehealth services including Medicare-covered telehealth services from your primary care physician, a nurse practitioner or physician's assistant affiliated with the primary care, individual sessions for mental health visits or individual sessions for psychiatric services. ▪ You have the option of getting these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider who offers the service by telehealth. ▪ Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare ▪ Telehealth services for monthly end-stage renal disease related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home ▪ Telehealth services to diagnosis, evaluate or treat of symptoms of an acute stroke, regardless of your location ▪ Telehealth services to members with a substance use disorder or co-occurring mental health disorder, regardless of their location	**$0.00** copay for each in-network Medicare-covered dental visit for care that is not considered routine. **$0.00** copay for each Medicare-covered hearing exam to diagnose a hearing condition. **$0.00** copay for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy. **$0.00** copay for defined Medicare-covered telehealth services from your primary care physician, a nurse practitioner or physician's assistant affiliated with network primary care, a network mental health provider or network psychiatric provider. All other specialties, Medicare-covered telehealth services will apply the applicable cost share found in this benefit chart based on their specialty. For LiveHealth Online services, please go to the Video Doctor Visits benefit later in this benefit chart. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Telehealth services for diagnosis, evaluation, and treatment of mental health disorders, if: ▪ You have an in-person visit within 6 months prior to your first telehealth visit ▪ You have an in-person visit every 12 months while receiving these telehealth services ▪ Exceptions can be made to the above for certain circumstances ▪ Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers ▪ Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** ▪ You're not a new patient **and** ▪ The check-in isn't related to an office visit in the past 7 days **and** ▪ The check-in doesn't lead to an office visit within 24 hours or soonest available appointment ▪ Evaluation of video and/or images you sent to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ▪ You're not a new patient **and** ▪ The evaluation isn't related to an office visit in the past 7 days **and** ▪ The evaluation doesn't lead to an office visit within 24 hours or soonest available appointment ▪ Consultation your doctor has with other doctors by telephone, internet, or electronic health record ▪ Second opinion by another network provider	

Services That Are Covered for You	What You Must Pay When You Get These Services
prior to surgery ▪ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) Prior authorization may be required.	
Podiatry services - Medicare-covered Covered services include: ▪ Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) ▪ Routine foot care for members with certain medical conditions affecting the lower limbs Prior authorization may be required.	**In-network:** **$0.00** copay for each Medicare-covered foot care visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Podiatry services - Supplemental This plan covers additional foot care services not covered by Original Medicare: ▪ Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for each supplemental foot care visit. Unlimited routine foot care visits each year. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: ▪ Digital rectal exam ▪ Prostate Specific Antigen (PSA) test	**In-network:** There is no coinsurance, copayment, or deductible for an annual PSA test. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. Prior authorization may be required.	**In-network:** **$0.00** copay for prosthetic devices and supplies. You must get prosthetic devices and supplies from a medical supply (DME) provider who works with this plan. They will not be covered if you buy them from a pharmacy. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Prior authorization may be required.	**In-network:** **$0.00** copay for each covered pulmonary rehabilitation visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 - 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Services to treat kidney disease Covered services include: ▪ Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney	**In-network:** **$0.00** copay for: ▪ Kidney dialysis when you use a provider in our plan or you are out of the service area for a short time ▪ Dialysis equipment or supplies

Services That Are Covered for You	What You Must Pay When You Get These Services
disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) ▪ Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) ▪ Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) ▪ Home dialysis equipment and supplies ▪ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”	▪ Dialysis home support services ▪ Each training session to learn how to care for yourself if you need dialysis **$0.00** copay for each covered kidney disease education service visit. You don't need the plan's approval before getting dialysis. But please let us know when you need to start this care so we can work with your providers. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
SilverSneakers SilverSneakers® Membership SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network** **$0.00** copay for the SilverSneakers® Fitness Program.

Services That Are Covered for You	What You Must Pay When You Get These Services
classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. [1]Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. [2]Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.	Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
SilverSneakers is not a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. SilverSneakers and SilverSneakers FLEX are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2020 Tivity Health, Inc. All rights reserved.	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 11 of this document. Skilled nursing facilities are sometimes called "SNFs.") 100 days per benefit period. No prior hospital stay required. Covered services include but are not limited to: ▪ Semiprivate room (or a private room if medically necessary) ▪ Meals, including special diets ▪ Skilled nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) ▪ Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used.	**In-network:** **$0.00** copay per stay for each skilled nursing facility stay. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit on how many benefit periods you can have. The hospital should tell the plan within one business day of any emergency admission. Your skilled nursing care benefits are based on the date of admission. If you are admitted in 2023 and are discharged in 2024, the 2023 copays will apply until you have not had any inpatient care in an acute hospital, a SNF, or an inpatient mental health facility for 60 days in a row.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Medical and surgical supplies ordinarily provided by SNFs ▪ Laboratory tests ordinarily provided by SNFs ▪ X-rays and other radiology services ordinarily provided by SNFs ▪ Use of appliances such as wheelchairs ordinarily provided by SNFs ▪ Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. ▪ A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) ▪ A SNF where your spouse is living at the time you leave the hospital Prior authorization may be required.	Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: ▪ Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication ▪ Be conducted in a hospital outpatient setting or a physician's office ▪ Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD ▪ Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-network:** **$0.00** copay for each covered SET session. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Prior authorization may be required.	
Transportation	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay. This plan offers coverage for 48, one-way, routine transportation services every year. Trips are limited to 60 miles. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. Urgently needed service coverage is worldwide.	**$0.00** copay for each covered urgently needed service. This plan covers worldwide urgent care services if you're traveling outside of the United States for less than six months. Coverage is limited to **$100,000** per year for worldwide urgent care and emergency services. This is a supplemental benefit. It's not covered by the Federal Medicare program. You must pay all costs over **$100,000** and all costs to return to your service area. You may be able to buy added travel insurance through an authorized agency. **$0.00** copay for each covered worldwide urgently needed service. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists and psychiatrists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health insurance card ready – you'll need it to answer some questions. **Sign up for Free:** ▪ You must enter your health insurance information during enrollment, so have your member ID card ready when you sign up. Benefits of a video doctor visit: ▪ The visit is just like seeing your regular doctor face-to-face, but just by web camera. ▪ It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. ▪ The doctor can send prescriptions to the pharmacy of your choice, if needed[1]. ▪ If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and see a therapist or psychologist in four days or less.[2] Appointments to a psychiatrist are typically scheduled within 14 days.[3] Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for video doctor visits using LiveHealth Online. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Services That Are Covered for You	What You Must Pay When You Get These Services
care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this plan. [1]Prescription is prescribed based on physician recommendations and state regulations (rules). LiveHealth Online is available in most states and is expected to grow more in the near future. Please see the map at livehealthonline.com for more service area details. [2]Appointments are based on therapist/ psychologist availability. Video psychologists or therapists cannot prescribe medications. [3]Appointments are based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	
Vision care - Medicare-covered Covered services include: ▪ Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts ▪ For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who	**In-network:** For in-network Medicare-covered vision care, you must use a provider in the Amerivantage Full Dual Coordination (HMO D-SNP) specialty medical network. You can find them in the Provider/Pharmacy Directory. To learn more, call the Customer Service number on the back cover of this document. **$0.00** copay for each Medicare-covered exam to treat an eye condition. After you have covered cataract surgery, **$0.00** copay for one pair of Medicare-covered

Services That Are Covered for You	What You Must Pay When You Get These Services
are age 50 and older and Hispanic Americans who are 65 or older. ▪ For people with diabetes, screening for diabetic retinopathy is covered once per year ▪ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Prior authorization may be required.	eyeglasses or contact lenses. Eye exams and early detection are important as some problems do not have symptoms. It matters to find problems early. Your doctor will tell you what tests you need. Talk to your doctor to see if you qualify. Eye exams and early detection are important as some problems do not have symptoms. It matters to find problems early. Your doctor will tell you what tests you need. Talk to your doctor to see if you qualify. Your medical vision benefit does not include a routine eye exam (refraction) for the purpose of prescribing glasses. If you have coverage under a supplemental benefit you will see that information in the section below. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Vision care - Supplemental The plan provides additional vision coverage not covered by Original Medicare. This plan covers 1 routine eye exam(s) every year. This plan covers up to **$425.00** for eyeglasses or contact lenses every year.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for one routine eye exam every calendar year. **$0.00** copay for eyewear each year up to the allowance amount. After plan paid benefits for eyeglasses (lenses and frames) or contact lenses, you are responsible for the remaining cost.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Benefits available under this plan cannot be combined with any other in-store discounts. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
Welcome to Medicare Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In-network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Medicaid benefits available under your plan

The benefits listed below are covered by your plan under TennCare. The benefits mentioned earlier in this *Evidence of Coverage* are covered by Medicare. For each benefit listed below, you can see what TennCare covers under your D-SNP plan.
Members with full Medicaid benefits may get the following services through Amerivantage Full Dual Coordination (HMO D-SNP):

Benefit	TennCare	Amerivantage Full Dual Coordination (HMO D-SNP)
Community health services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this

Benefit	TennCare	Amerivantage Full Dual Coordination (HMO D-SNP)
		chapter for any additional coverage.
Dental services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. Medicaid eligibility determines Medicaid covered benefits (for children under age 21). Dental Services provided by the State, not the TN Health Plan.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Durable medical equipment	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Early and periodic screening, diagnosis and treatment (EPSDT) services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. For TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Emergency air and ground transportation services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Home health care	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. Home health benefits are limited for adults as follows: Part-time or intermittent nursing services must be no more than 1 visit per day, lasting less than 8 hours, and no more than 27 total hours of nursing care per week. Part-time or intermittent nursing services are not covered if the only skilled nursing function is administration of medication on an as needed basis. Home	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.

Benefit	TennCare	Amerivantage Full Dual Coordination (HMO D-SNP)
	health aide services must be provided at no more than 2 visits per day, with care provided less than or equal to 8 hours per day. Nursing services and home health aide services combined must total less than or equal to 8 hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 nursing care.	
Hospice care	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Inpatient and outpatient substance abuse benefits	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Inpatient hospital services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. Inpatient rehab hospital is not covered for ages 21 years old and older unless it's considered a cost-effective alternative.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Lab & x-ray services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Medical supplies	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Mental health case management	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Mental health crisis services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.

Benefit	TennCare	Amerivantage Full Dual Coordination (HMO D-SNP)
Non-emergency transportation services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. Covered as necessary for enrollees lacking accessible transportation for TennCare-covered services. Travel to access primary care and dental services must meet certain requirements.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Occupational therapy	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Organ and tissue transplant services and donor organ/ tissue procurement services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Outpatient hospital services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Outpatient mental health services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Pharmacy services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. Pharmacy services are provided by State, not TN Health Plan.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Physical therapy services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Physician services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Private duty nursing	Covered, with prior approval and with certain limitations for adults age 21 and older, when prescribed by attending	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.

Benefit	TennCare	Amerivantage Full Dual Coordination (HMO D-SNP)
	physician for treatment and service rendered by a registered nurse a licensed practical nurse	
Psychiatric inpatient facility services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Psychiatric rehabilitation services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Reconstructive breast surgery	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Renal dialysis clinic services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Speech therapy services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.
Vision services	Covered by Medicaid if service is medically necessary. May be based on your eligibility level. For children under age 21. For 21 and over, medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary.	Check the plan's Medical Benefit Chart earlier in this chapter for any additional coverage.

Section 2.2

TennCare CHOICES long-term services and supports programs

CHOICES

What is CHOICES?
TennCare CHOICES in long-term services and supports (or CHOICES for short) is for adults (age

21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services to help a person live in their own home or in the community. These services are called home- and community-based services or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if it is needed.

How do I apply for CHOICES?

If you think you need long-term services and supports, call us at 1-866-840-4991. We may use a short screening that will be done over the phone to help decide if you may qualify for CHOICES. If the screening shows that you don't appear to qualify for CHOICES, you'll get a letter that says how you can finish applying for CHOICES.

If the screening shows that you might qualify for CHOICES, or if we don't conduct a screening over the phone, we will send a Care Coordinator to your home to do an assessment. The purpose of the in-home assessment is to help you apply for CHOICES. It's also to find out:

- The kinds of help you need;
- The kinds of care being provided by family members and other caregivers to help meet your needs;
- **And** the gaps in care for which paid long-term services and supports may be needed.

If you want to receive care at home or in the community (instead of going to a nursing home), the assessment will help decide if your needs can be safely met in the home or community setting.

And, for CHOICES Group 2 (you can read about all of the CHOICES Groups below), it will help decide if the cost of your care would exceed the cost of nursing home care.

This doesn't mean that you will receive services up to the cost of nursing home care. CHOICES won't pay for more services than you must have to safely meet your needs at home. And, CHOICES only pays for services to meet long-term services and supports needs that can't be met in other ways.

CHOICES services provided to you in your home or in the community will not take the place of care you get from family and friends or services you already receive. If you're getting help from community programs, receive services paid for by Medicare or other insurance, or have a family member that takes care of you, these services will not be replaced by paid care through CHOICES. Instead, the home care you receive through CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in CHOICES will be provided as cost-effectively as possible so that more people who need care will be able to get help.

However, if you have been getting services through the State-funded Options program, you won't qualify to get those services anymore. They are for people who don't get Medicaid. And if you've been getting services from programs funded by the Older Americans Act (like Meals on Wheels, homemaker, or the National Caregiver Family Support Programs) that you can now get through CHOICES, you'll get the care you need through CHOICES.

If you want home care, the Care Coordinator will also perform a risk assessment. This will help to identify any additional risks you may face as a result of choosing to receive care at home. It will also help to identify ways to help reduce those risks and to help keep you safe and healthy.

To see if you qualify to enroll in CHOICES, call us at 1-866-840-4991.

Does someone you know that isn't on TennCare want to apply for CHOICES? They should contact their local Area Agency on Aging and Disability (AAAD) for free at 1-866-836-6678. Their local AAAD will help them find out if they qualify for TennCare and CHOICES.

Who can qualify to enroll in CHOICES?

For now, there are three (3) groups of people who can qualify to enroll in CHOICES.

CHOICES Group 1 is for people of all ages who receive **nursing home care**.

To be in CHOICES Group 1, you must:

- Need the level of care provided in a nursing home;
- **And** qualify for Medicaid long-term services and supports;
- **And** receive nursing home services that TennCare pays for.

TennCare long-term services and supports will decide if you need the level of care provided in a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports. We'll help you fill out the papers TennCare needs to decide. What if TennCare says yes? If you're receiving nursing home services that TennCare will pay for, TennCare will enroll you into CHOICES Group 1. If TennCare says you don't qualify, you'll get a letter that sayswhy. It will say how to appeal if you think it's a mistake.

CHOICES Group 2 is for certain people who **qualify for nursing home care, but choose to receive home care instead**.

To be in CHOICES Group 2, you must:

- Need the level of care provided in a nursing home;
- **And** qualify for Medicaid long-term services and supports because you receive SSI payments OR because you need and **will receive** home care services instead of nursing home care;
- **And** be an adult 65 years of age or older;
- **Or** be an adult 21 years of age or older with a physical disability.

If you need home care services, but don't qualify in one of these groups, you can't be in CHOICES Group 2, but you may qualify for other kinds of long-term services and supports.

TennCare long-term services and supports will decide if you need the level of care provided in a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide.

If TennCare says yes, to enroll in CHOICES Group 2 and begin receiving home care services:

- We must be able to safely meet your needs at home.
- **And** the cost of your home care can't be more than the cost of nursing home care. The cost of your home care includes any home health or private duty nursing care you may need.

If we can't safely meet your needs at home, or if your care would cost more than nursing home care, you can't be in CHOICES Group 2. But, you may qualify for other kinds of long-term services and supports.

If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 3 is for certain people who **don't qualify for nursing home care, but need home care to help them stay at home safely**.

To be in CHOICES Group 3, you must:

- Be “at risk” of going into a nursing home unless you receive home care;
- And qualify for Medicaid long-term services and supports because you receive SSI payments OR because you need and will receive home care services to keep you from going into a nursing home;
- And be an adult 65 years of age or older;
- Or be an adult 21 years of age or older with a physical disability.

TennCare Long-Term Services and Supports will decide if you are “at risk” of going into a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We’ll help you fill out the papers they need to decide.

If TennCare says yes, to enroll in CHOICES Group 3 and begin receiving home care services, we must be able to safely meet your needs at home with the care you’d get in CHOICES Group 3.

If we can’t safely meet your needs with the care you’d get in CHOICES Group 3, you can’t be in CHOICES Group 3. But, TennCare may decide that you qualify for other kinds of long-term services and supports, including nursing home care.

Limits on Enrollment into CHOICES Group 2

Not everyone who qualifies to enroll in CHOICES Group 2 may be able to enroll. There is an enrollment target for CHOICES Group 2. It’s like a limit on the number of people who can be in the group at one time. (The number of people who can enroll is sometimes called “slots.”) This helps to ensure that the program doesn’t grow faster than the State’s money to pay for home care. It also helps to ensure that there are enough home care providers to deliver needed services.

The enrollment target for the number of slots that can be filled in CHOICES Group 2 will be set by the State in TennCare Rules. It doesn’t apply to people moving out of a nursing home. And, it may not apply to some people who are on TennCare that would have to go into a nursing home right away if less costly home care isn’t available. We must decide if you would go into a nursing home right away and provide proof to TennCare. And, we must show TennCare that there are home care providers ready to start giving your care at home.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person is leaving the hospital and will be admitted to a nursing home if home care isn’t available. Reserved slots won’t be used until all of the other slots have been filled. The number of reserved slots and the guidelines to qualify in one of those slots is in TennCare Rules. If the only slots left are reserved, you’ll have to meet the guidelines for reserved slots to enroll in CHOICES Group 2.

If you don’t meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in CHOICES Group 2, your name will be placed on a waiting list. Or, you can choose to enroll in CHOICES Group 1 and receive nursing home care. There is no limit on the number of people that can be enrolled in Group 1 and go into a nursing home. (But, you don’t have to receive nursing home care unless you want to. You can wait for home care instead.)

People enrolled in CHOICES Group 2 above the enrollment target must get the first slots that open up. (These are people who have moved out of nursing homes or people already on TennCare and would have gone into a nursing home right away if less costly home care wasn’t available.) When everyone in CHOICES Group 2 is under the enrollment target and there are still slots

available, TennCare can enroll from the waiting list based on need.

What long-term services and supports are covered in CHOICES?

The covered long-term services and supports you can receive in CHOICES depend on the CHOICES Group you're enrolled in. If you enroll in CHOICES, TennCare will tell you which CHOICES Group you're in. There are three (3) CHOICES Groups.

People in **CHOICES Group 1** receive nursing home care.

People in **CHOICES Group 2** need the level of care provided in a nursing home but receive **home care** (or HCBS) instead of nursing home care.

People in **CHOICES Group 3** receive **home care** (or HCBS) to prevent or delay the need for nursing home care.

Here are the kinds of home care covered in CHOICES Group 2 and Group 3. Some of these services have limits. This means that TennCare will pay for only a certain amount of these services. The kind and amount of care you get in CHOICES depends on your needs.

- **Personal care visits** up to two visits per day, lasting no more than four hours per visit; there must be at least 4 hours between each visit) — Someone will help you with personal care needs and support in the home, on the job, or in the community. Do you need this kind of personal care? If you do, the worker giving your personal care visits can also help with household chores like fixing meals, cleaning, or laundry. And they can run errands like grocery shopping or picking up your medicine. They can only help with those things **for you**, not for other family members who aren't in CHOICES. And they can only do those things if there's no one else that can do them for you.
- **Attendant care** (up to 1,080 hours per calendar year) — The same kinds of help you'd get with personal care visits, but for longer periods of time (more than four hours per visit or visits less than four hours apart). You can only get attendant care when your needs can't be met with shorter personal care visits. Do you need help with personal care and also need help with household chores or errands? If so, your attendant care limit increases to up to 1,400 hours per calendar year. This higher limit is only for people who also need help with household chores or errands. How much attendant care you get depends on your needs.
- **Home-delivered meals** (up to 1 meal per day).
- **Personal Emergency Response System —** A call button so you can get help in an emergency when your caregiver is not around.
- **Adult day care** (up to 2,080 hours per calendar year) — A place that provides supervised care and activities during the day.
- **In-home respite care** (up to 216 hours per calendar year) — Someone to come and stay with you in your home for a short time so your caregiver can get some rest.
- **In-patient respite ca**re (up to 9 days per calendar year) — A short stay in a nursing home or assisted care living facility so your caregiver can get some rest.
- **Assistive technology** (up to $900 per calendar year) — Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.
- **Minor home modifications** (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) — Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.

- **Pest control** (up to 9 units per calendar year) — Spraying your home for bugs or mice.
- **Assisted care living facility** — A place you live that helps with personal care needs, homemaker services, and taking your medicine. You must pay for your room and board.
- **Critical adult care home** — A home where you and no more than four other people live with a health care professional that takes care of special health and long-term care needs. (Under state law, available only for people who are ventilator dependent or who have traumatic brain injury. You must pay for your room and board.) Critical adult care homes are available for Group 2 members ONLY.
- **Companion care** — Someone you hire who lives with you in your home to help with personal care or light housekeeping whenever you need it. (Available only for people in Consumer Direction who are in Group 2 and who need care off and on during the day and night that can't be provided by unpaid caregivers. And only when it costs no more than other kinds of home care that would meet your needs.)
- **Community living supports (CLS)** — A shared home or apartment where you and no more than three other people live. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation, and other supports needed to remain in the community.
- **Community living supports** – Family Model (CLS-FM) — A shared home or apartment where you and no more than three other people live with a trained host family. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation, and other supports needed to remain in the community.

Care Coordination and Role of the Care Coordinator

In CHOICES, we are responsible for managing all of your physical health, behavioral health (mental health, alcohol or drug abuse) and long-term services and supports needs, and the services that you receive to address these needs. This is called care coordination.

These functions are carried out by a Care Coordinator. We will assign you a Care Coordinator when you enroll in CHOICES. Your Care Coordinator will play a very important role. Your Care Coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services.

Your Care Coordinator will…

- Provide information about CHOICES and answer your questions.
- Help you get the right kind of long-term services and supports in the right setting for you to address your needs.
- Coordinate all of your physical health, behavioral health (mental health, alcohol or drug abuse) and long-term services and supports needs.
- Help to fix problems and answer questions that you have about your care.
- Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be "at risk" of going into a nursing home.
- Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.

Other tasks performed by the Care Coordinator will vary slightly depending on the CHOICES Group you're enrolled in.

If you receive nursing home care in CHOICES Group 1, your Care Coordinator will…

- Be part of the care planning process with the nursing home where you live.
- Perform any additional needs assessment that may be helpful in managing your health and long term services and supports needs.
- Supplement (or add to) the nursing home's plan of care if there are things Amerigroup can do to help manage health problems or coordinate other kinds of physical and behavioral health (mental health, alcohol or drug abuse) care you need.
- Conduct face-to-face visits at least every six months.
- Coordinate with the nursing home when you need services the nursing home isn't responsible for providing.
- Determine if you're interested and able to move from the nursing home to the community and if so, help make sure this happens timely.

If you receive home care in CHOICES Group 2 or Group 3, your Care Coordinator will work with you to...

- Do a comprehensive, individual assessment of your health and long-term services and supports needs; and
- Develop a **Person-Centered Support Plan**.

This is your plan that helps guide the services and supports you will receive. Your support plan tells the people who will support you:

- **What is important to you** — the things that really matter to you;
- **What is important for you** — the supports you need to stay healthy and safe, and achieve your goals; and
- **How to support you** to have those things in your life.

Your support plan must include:

- Your strengths and needs,
- The goals you want to reach,
- The services and supports (paid and unpaid) you will receive to help you meet your goals,
- How often you will receive those service and supports,
- Who will provide them, and
- The settings (or places) they will be provided.

Your Care Coordinator helps develop your support plan.

Your Care Coordinator will help you to:

- Identify the services and supports you need,
- Explore employment options and ways to be part of your community and build relationships,
- Decide what services and supports you will need to meet your needs and reach your goals,
- Develop and access other services and unpaid supports to help too,
- Understand all of the services, providers and settings you can choose from,
- Choose the services you will receive, your provider for each service, and settings (places) where you will receive those services,
- Write your support plan based on your choices, preferences, and support needs, and
- Make sure you get the services in your support plan.

Your support plan is very important. CHOICES can only pay for covered services that are part of an approved support plan. How your support plan is developed is also very important. Your support plan should be developed in a way that makes sure:

- You get to lead the planning process.
- You receive the help you need to lead the planning process.
- You get to make choices and to have the information you need to make those choices.
- You have help from family, friends, advocates or anyone else you choose.
- You get to speak for yourself.

- You can have someone to speak for you and choose that person.
- You have and use an interpreter if the language you speak or understand is not English.

Your support plan should also be developed in a way that makes sure:

- You get to talk with your Care Coordinator before the planning meeting if you want to.
- You get to pick who to invite to the meeting (and decide if you don't want someone there).
- The planning meeting is set at times and places that work best for you.
- You get to help choose service providers before services begin, and at any time during the year if you want to change providers. Amerigroup will try to give you the providers you want. (The provider must be contracted with your MCO and willing and able to provide your services.)
- You can choose to direct (or stop directing) some or all of the services that are part of Consumer Direction at any time.
- You sign your support plan.
- And, everyone who will provide services and supports (paid and unpaid) signs your support plan saying they are committed to implement your plan as written. Your support plan is usually in effect for a year. But you can ask to change your support plan anytime during the year if your needs change or your situation changes.

Your Care Coordinator will also …

- Make sure your plan of care is carried out and working the way that it needs to.
- Monitor to make sure you are getting what you need and that gaps in care are addressed right away.
- Contact you by telephone at least once every month and visit you in person at least once every three months if you are in Group 2 or contact you by telephone at least once every three months and visit you in person at least once every six months if you are in Group 3.
- Make sure the home care services you receive are based on your goals, needs and preferences and do not cost more than nursing home care, if you are in Group 2, or more than $15,000 if you are in Group 3.

We will tell you who your Care Coordinator is and how to reach them. If your Care Coordinator won't be assigned soon after you enroll in CHOICES, we will send a letter that says how to reach the Care Coordination Unit for help until your Care Coordinator is assigned.

Requesting a TennCare review

If you're in CHOICES Group 2 or Group 3, you can ask TennCare to review your needs assessment or support plan if you have concerns and think you're not getting the services you need. TennCare will review the assessment or plan of care and the information gathered by your Care Coordinator.

If TennCare thinks you're right, they'll work with us to fix the problem. If TennCare thinks you are getting the services you need, they'll send you a letter that says why.

To request an objective review of your needs assessment and support plan, you must submit a written request to:

TennCare Division of Long-Term Services and Supports
c/o CHOICES Review
310 Great Circle Rd.
Nashville, TN 37243

Keep a copy of your request. Write down the date that you sent it to TennCare.

Or, **fax** your request to **1-615-532-9140. Keep the page** that shows your fax went through.

Changing Care Coordinators

If you're unhappy with your Care Coordinator and would like a different one, you can ask us. You can have a new Care Coordinator if one is available. That doesn't mean you can pick whoever you want to be your Care Coordinator. We must be able to meet the needs of all CHOICES members and assign staff in a way that allows us to do that. To ask for a different Care Coordinator, call us at **1-866-840-4991**. Tell us why you want to change Care Coordinators. If we can't give you a new Care Coordinator, we'll tell you why. And, we'll help to address any problems or concerns you have with your Care Coordinator.

There may be times when we will have to change your Care Coordinator. This may happen if your Care Coordinator is no longer with Amerigroup, is temporarily not working, or has too many members to give them the attention they need. If this happens, we will send you a letter that says who your new Care Coordinator will be and how to contact them.

If you're in CHOICES, you can contact your Care Coordinator anytime you have a question or concern about your health care — you do not need to wait until a home visit or a phone call. You should contact your Care Coordinator anytime you have a change in your health condition or other things that may affect the kind or amount of care you need. If you need help after regular business hours that won't wait until the next day, you can call us at 1-866-840-4991.

CHOICES Consumer Advocate

In addition to your Care Coordinator, there is another person at Amerigroup to help you. This person is the CHOICES Consumer Advocate. The CHOICES Consumer Advocate is available to:

- Provide information about the CHOICES program.
- Help you figure out how things work at Amerigroup, like filing a complaint, changing Care Coordinators or getting the care you need.
- Make referrals to the right Amerigroup staff
- Help fix problems with your care.

To reach the Amerigroup CHOICES Consumer Advocate, call us at **1-866-840-4991**. Ask to speak with the CHOICES Consumer Advocate.

Freedom of choice

In CHOICES, if you need the level of care provided in a nursing home, you have the right to choose to get care:

- In your home,
- Or in another place in the community (like an assisted living facility or critical adult care home),
- Or in a nursing home.

To get care in your home or in the community, you must qualify and be able to enroll in CHOICES Group 2 or CHOICES Group 3. (See **Who can qualify to enroll in CHOICES?**)

If you're in a nursing home, you may be able move from your nursing home to your own home and receive services if you want to. If you're interested in moving out of the nursing home into the community, talk with your Care Coordinator.

To get care in your home or in the community, we must be able to safely meet your needs in that setting. And, for CHOICES Group 2, the cost of your care can't be more than the cost of your care in a nursing home. That includes the cost of your home care **and** any home health or nursing care you may need. For CHOICES Group 3, the cost of your care can't be more than $15,000 per year. Minor home modifications, and any home health or nursing care you might need

don't count against the $15,000 limit. The actual kind and amount of care you will receive depends on your needs.

What if you qualify for nursing home care but don't want to leave the nursing home and move to the community? Then, we won't make you, even if we think care in the community would cost less. As long as you qualify for nursing home care, you can choose to receive it.

You can change your choice at any time as long as you qualify and can enroll to receive care in the setting you pick.

In CHOICES, you can also help choose the providers who will give your care. This could be an assisted living or nursing home, or the agency who will give your care at home. You may also be able to hire your own workers for some kinds of care (called Consumer Direction).

The provider you choose must be willing and able to give your care. Your Care Coordinator will try to help you get the provider you pick. But, if you don't get the provider you want, you can't appeal and get a fair hearing. If you don't get the services you think you need, then you can file an appeal.

Using long-term services and supports providers who work with Amerigroup

Just like physical and behavioral health services, you must use providers who work with us for most long-term services and supports. You can find the *Provider/Pharmacy Directory* online at www.myamerigroup.com/TN. Or call us at **1-800-600-4441** to get a list. Providers may have signed up or dropped out after the list was printed. But, the online Provider Directory is updated every week. You can also call us at **1-800-600-4441** to find out if a provider is in our network.

In most cases, you must receive services from a long-term services and supports provider on this list so that TennCare will pay for your long-term services and supports. However, there are times when TennCare will pay for you to get care from a long-term services and supports provider who does not usually work with us. But, we must first say that it is OK to use a long-term services and supports provider who does not usually work with Amerigroup.

Prior authorization of long-term services and supports

Sometimes you may have to get an **ok** from us for your physical or behavioral health (mental health, alcohol or drug abuse) services before you receive them even if a doctor says you need the services. This is called prior authorization. Services that must have a prior authorization before you receive them will only be paid for if we say ok **before** the services are provided.

All long-term services and supports must be approved before we will pay for them. All **home care services** must be approved before you receive them. Nursing home care may sometimes start before you get an **ok**, but you still need an **ok** before we will pay for it. We will not pay for any long-term services and supports unless you have an **ok**.

Consumer Direction

Consumer Direction is a way of getting some of the kinds of home care you need. It offers more choice and control over **who** gives your home care and **how** your care is given. The services available through Consumer Direction are:

- Personal care visits;
- Attendant care;
- In-home respite; and
- Companion care (only if you qualify for and are enrolled in CHOICES Group 2).

In Consumer Direction, you actually employ the people who give some of your home care services — they work **for you** (instead of a provider). You must be able to do the things that an employer would do. These include things like:

Hiring and training your workers:

- Find, interview and hire workers to provide care for you.
- Define workers' job duties.
- Develop a job description for your workers.
- Train workers to deliver your care based on your needs and preferences.

Setting and managing your workers' schedule:

- Set the schedule at which your workers will give your care.
- Make sure your workers use the call-in system to log in and out every time they work.
- Make sure your workers provide only as much care as you are approved to receive.
- Make sure that no hourly worker gives you more than 40 hours of care in a week.

Supervising your workers:

- Supervise your workers.
- Evaluate your workers' job performance.
- Address problems or concerns with your workers' performance.
- Fire a worker when needed.

Overseeing workers' pay and service notes:

- Decide how much your workers will be paid (within limits set by the State).
- Review the time your workers report to be sure it's right.
- Ensure there are good notes kept in your home about the care your workers provide.

Having and using a back-up plan when needed:

- Develop a back-up plan to address times that a scheduled worker doesn't show up (you can't decide to just go without services).
- Activate the back-up plan when needed.

What if you can't do some or all of these things?

Then you can choose a family member, friend, or someone close to you to do these things for you. It's called a "Representative for Consumer Direction." It's important that you pick someone who knows you very well that you can depend on.

To be your Representative for Consumer Direction, the person must:

- Be at least 18 years of age.
- Know you very well.
- Understand the kinds of care you need and how you want care to be given.
- Know your schedule and routine.
- Know your health care needs and the medicine you take.
- Be willing and able to do all of the things that are required to be in Consumer Direction.
- Live with you in your home or be present in your home often enough to supervise staff. This usually means at least part of every worker's shift. But, it may be less as long as it's enough to be sure you're getting the quality of care you need.
- Be willing to sign a Representative Agreement, saying they agree to do these things.

Your Representative cannot get paid for doing these things

You or your Representative will have help doing some of the things you must do as an employer.

The help will be provided by Public Partnerships, LLC. There are 2 kinds of help you will receive:

1. Public Partnerships, LLC will help you and your workers fill out all of the paperwork that you must complete. They will pay your workers for the care they give. And, they will fill out and file

the payroll tax forms that you must fill out as an employer.

2. Public Partnerships, LLC will hire or contract with a Supports Broker for you. A Supports Broker is a person who will help you with the other kinds of things you must do as an employer. These are things like:

- Writing job descriptions;
- Helping you and your workers with paperwork and training;
- Scheduling workers based on your support plan; and
- Developing an initial back-up plan to address times when a scheduled worker doesn't show up.

But, your Supports Broker can't help you supervise your workers. You or your Representative must be able to do that by yourself.

The kind and amount of care you'll get depends on what you need. Those services are listed in your support plan. You won't be able to get more services by choosing to be in Consumer Direction. You can only get the services you need that are listed in your support plan.

You can choose to get some of these services through Consumer Direction and get some home care from providers that work with your TennCare health plan. But, you must use providers that work with Amerigroup for care that you can't get through Consumer Direction.

Can you pay a family member or friend to provide care in Consumer Direction? Yes, you can pay a family member, but you cannot:

- Pay your spouse to provide care;
- Pay someone who lives with you to provide Attendant Care, Personal Care, or In-home Respite services;
- Pay an immediate family member to provide Companion Care. An immediate family member is a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition;
- Pay someone who lives with you now or in the last 5 years to provide Companion Care.

And, CHOICES can't pay family members or others to provide care they would have given for free. CHOICES only pays for care to meet needs that **can't** be met by family members or others who help you. The services you need are listed in your support plan.

If you're in CHOICES and need services that can be consumer directed your Care Coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your Care Coordinator will work with you to decide which of the services you will direct and start the process to enroll you in Consumer Direction. Until Consumer Direction is set up, you will get the services that are in your support plan from a provider who works with Amerigroup, unless you choose to wait for your Consumer Directed workers to start. **If you choose** to wait for your Consumer Directed workers to start, you must have supports in place to give you the care you need.

You can decide to be in Consumer Direction at any time. If you are directing one or more services and decide not to be in Consumer Direction any more, you will not stop getting long-term services and supports. You will still be in CHOICES. You'll get the services you need from a provider who works with Amerigroup instead.

Self-direction of health care tasks

If you're in Consumer Direction, you may also choose to have consumer directed workers

perform certain kinds of health care tasks for you. Health care tasks are routine things like taking prescribed drugs that most people do for themselves every day. Usually, if you can't perform health care tasks yourself and don't have a family member to do them for you, they must be performed by a licensed nurse. But, in Consumer Direction, if your doctor says it's OK, you can have your consumer directed workers do certain kinds of health care tasks for you. You (or your Representative) must be able to train your workers on how to do each health care task, and must supervise them in performing the task.

Please talk with your Care Coordinator if you have any questions about self-direction of health care tasks.

Paying for your CHOICES long-term services and supports

You may have to pay part of the cost of your care in CHOICES. It's called **"patient liability."** The amount you pay depends on your income. If you have patient liability, you **must** pay it in CHOICES.

If you get care in an assisted living or adult care home, or in a nursing home, you will pay your patient liability to that home. If you get care in your own home, you will pay your patient liability to Amerigroup.

Do you have medical bills for care you got before your TennCare started? This includes care in a nursing home, or Medicare copays or deductibles.

Or, do you have medical bills for care you got after TennCare started that TennCare doesn't cover? This includes eye glasses, hearing aids, and dental care for adults.

We may be able to subtract those bills from the patient liability you owe each month. This means your patient liability will be less. (It can even be zero.) We'll keep subtracting those bills until the total cost of your medical bills has been subtracted.

The bills must be for care you got in the 3 months before the month you applied to TennCare. For example, if you apply for TennCare in April, the bills must be for January, February, and March.

These can be bills you've already paid. Or they can be bills you haven't paid yet. But you must be expected to pay them. (You don't have other insurance to pay for them.) What if a family member or someone else paid these bills? Send them only if they expect you to pay them back.

If you have medical bills like this, send them to TennCare. There are 2 ways to get them to us. By mail:

TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

By fax: 1-855-315-0669

On each page you send, be sure to write "for patient liability" and include your name and Social Security number.

What if you DON'T pay the patient liability you owe?

Four things could happen:

1. Your CHOICES care provider could decide not to provide your care anymore. If you get care in an assisted living or adult care home, or in a nursing home, they could discharge you. Before they do, they must send you a letter that says why you're being discharged. If you think they're wrong about owing them money, you can appeal.

2. **And** if you don't pay your patient liability, other providers may not be willing to give your care either. If that happens, Amerigroup could decide not to be your health plan for CHOICES anymore. We can't meet your needs if we can't find any providers willing to give you care. We must send you a letter that says why we can't be your health plan for CHOICES anymore. If you think we're wrong, you can appeal.

3. **And** if you don't pay your patient liability, other TennCare health plans may not be willing to be your health plan for CHOICES either. If that happens, you may not be able to stay in CHOICES. You may not get **any** long-term services and supports from TennCare. If you can't stay in CHOICES, TennCare will send you a letter that says why. If you think they're wrong, you can appeal.

4. And if you can't stay in CHOICES, you may not qualify for TennCare anymore. If the only way you qualify for TennCare is because you get long-term services and supports, you could lose your TennCare too. Before your TennCare ends, you'll get a letter that says how to appeal if you think it's a mistake.

If you have patient liability, it's very important that you pay it

Do you have Medicare or other insurance that helps pay for your long-term services and supports? If you do, that insurance must pay **first**. TennCare can't pay for care that's covered by Medicare or other insurance. What if you have long-term services and supports insurance that pays you? Then you must pay the amount you get to help cover the cost of your care. If you live in an assisted living or adult care home, or in a nursing home, you'll pay the amount you get to that home. If you get care in your own home, your Care Coordinator will tell you how to pay the insurance money you get. This **won't** lower the amount of any patient liability you owe. You must pay any long-term services and supports insurance you get **and** your patient liability to help cover the cost of your care. But, you won't pay more than the total cost of long-term services and supports you receive that month.

What if you receive Aid and Attendance Benefits through the Department of Veterans Affairs? If you do, it is important that you tell your Care Coordinator. Your Care Coordinator will give you important information that will help you make choices about how you will receive the long-term services and supports that you need.

Disenrollment from CHOICES

Your enrollment in CHOICES and receipt of long-term services and supports can end for several reasons and may vary depending on the CHOICES Group that you are enrolled in. We can recommend a member's disenrollment from CHOICES but TennCare will make the final decision.

Some of the reasons you could be disenrolled from CHOICES include:

- You no longer qualify for Medicaid.
- You no longer need the level of care provided in a nursing home and you're not at risk of going into a nursing home.
- You no longer need and aren't receiving any long-term services and supports.
- You do not pay your patient liability.

If you're in Group 2 or Group 3, your enrollment in CHOICES can also end if …

We decide we can no longer safely meet your needs in the home or community, and you refuse to move to a nursing home. Reasons we may not be able to safely meet your needs include things like:

- You refuse to allow a Care Coordinator into your home. If a Care Coordinator can't visit

you in your home, we can't be sure that you're safe and healthy.
- The risk of harm to you or to people providing care in your home is too great.
- Even though there are providers available to provide care, none of those providers are willing to provide your care.
- You refuse to receive services that are identified in your person-centered support plan as needed services.

If you're in Group 2, you can also be disenrolled if:

The cost of care you need in the home or community will be more than the cost of nursing home care. The cost of care includes any home health or private duty nursing you may need.

Your Care Coordinator will check regularly to make sure that the care you receive in your own home or in the community (including the cost of home health and private duty nursing) does not exceed the cost of nursing home care.

If we decide that home care will cost more than nursing home care, your Care Coordinator will work with you to try to put together a support plan that will safely and cost-effectively meet your needs. If we decide it's not possible to safely serve you in your home or in the community for no more than the cost of nursing home care, your Care Coordinator will help you move to a nursing home of your choice who works with Amerigroup. If you choose not to move to a nursing home, you'll no longer be able to receive services in your own home or in the community. You'll be disenrolled from CHOICES.

If you're in Group 3:

We must be able to safely meet your needs with the care you can get in CHOICES Group 3. This includes CHOICES home care up to $15,000 per year (not counting minor home modifications) other Medicaid services you qualify to receive from your MCO, services you can get through Medicare, private insurance or other funding sources, and unpaid care provided by family members and friends. If we decide your needs can't be met with the care you can get in Group 3, TennCare will see if you qualify to move to CHOICES Group 2 for more home care or CHOICES Group 1 for nursing home care. What if your needs can't be met at home or in the community (even with home care up to the cost of nursing home care) and you choose not to move to a nursing home? Then, you will be disenrolled from CHOICES.

If you're disenrolled from CHOICES, you'll stay on TennCare as long as you still qualify for Medicaid. However, you'll no longer receive any long-term services and supports paid for by TennCare. You'll get a letter that says why your CHOICES is ending and how to appeal if you think it's a mistake.

If the only way you qualify for Medicaid is because you receive long-term services and supports and you're disenrolled from CHOICES, your TennCare may end too. Before it does, you'll get a letter that says why. You'll get a chance to qualify in another one of the groups that Medicaid covers.

Long-Term Care Ombudsman

The State's Long-Term Care Ombudsman program offers assistance to persons living in nursing homes or other community-based residential settings, like an assisted living or critical adult care home. A Long-Term Care Ombudsman does **not** work for the facility, the State, or Amerigroup. This helps them to be fair and objective in resolving problems and concerns.

The Long-Term Care Ombudsman in each area of the State can:

- Provide information about admission to and discharge from long-term services and supports facilities.
- Provide education about resident rights and responsibilities.
- Help residents and their families resolve questions or problems they have been unable to address on their own with the facility. Concerns can include things like:
  - Quality of care;
  - Resident rights; or
  - Admissions, transfers, and discharges.

To find out more about the Long-Term Care Ombudsman program, or to contact the Ombudsman in your area, call the Tennessee Commission on Aging and Disability for free at **1-877-236-0013**.

Ombudsman for people receiving Community Living Supports in CHOICES.

Community Living Supports are services for people who can no longer live alone, but don't have family that can give the help they need. If you're in CHOICES and want Community Living Supports, you will have an Ombudsman to help you. This Ombudsman works for the Area Agency on Aging and Disability in your area. Amerigroup will give them your name and they will call you. Your Ombudsman can help you:

- Understand your rights and responsibilities. This includes your right to decide if you want these services, who provides your services, where you live, and who you live with.
- Exercise your rights when you need help.
- Fix quality concerns or other problems you can't fix with your provider or health plan.
- Contact other places that can help you when you need it.
- Understand, identify and report abuse, neglect, or exploitation.

Paying TennCare Back for the Services You Get in Long-Term Services and Supports: Estate Recovery

What is Estate Recovery and what does it mean for you?

Your **"estate"** is made up of the things you own that you leave behind when you die. It includes your money, your home, other property, or other things you own. Estate recovery is using the value of things you leave behind when you die to pay TennCare back for care you received while you were living.

Why you have to pay TennCare back for your care.

TennCare services are paid for by the State and federal government. If TennCare pays for certain kinds of care, TennCare is required by federal law to try to get paid back for that care after your death.

Who has to pay TennCare back for their care.

TennCare must ask to be repaid for money it spent on your care if you are:

- Any age and got nursing home care if you weren't expected to return home (this includes carein an intermediate care facility for individuals with intellectual disabilities or ICF/IID).
- Or age 55 and older and got care in a nursing home or ICF/IID, home care — called home and community based services or HCBS, home health or private duty nursing.

What kinds of care must be paid back to TennCare.

TennCare **must** ask to be repaid for:

- Care in a nursing home or ICF/IID.
- Home care or HCBS (as well as home health or private duty nursing).
- Hospital care and prescription drugs you got while you're getting long-term services and supports.

TennCare can also ask to be paid back for the cost of **any other** care we paid for.

How much your estate will have to pay TennCare back for your care

TennCare is a managed care program. This means that TennCare contracts with health plans to provide the services you need. This includes health and mental health services and some long-term services and supports (like care in a nursing home or some kinds of home care).

TennCare pays your health plan a monthly payment for care they are contracted to provide. The payment is based on the kinds of services you are expected to receive from your health plan. It takes into account things like your age, if you have a disability, and if you receive long-term services and supports. Part of that payment is for the kinds of care that must be paid back to TennCare.

The payment made to your health plan is the same each month, no matter what services you actually receive that month. The monthly payment to a health plan may exceed $5,000 per month for people who receive long-term services and supports. It can also vary depending on which health plan you have and the part of the state you live in.

Federal rules say that the amount of money TennCare must be paid back for care you got from your health plan is the amount TennCare paid your health plan for those services. This may be different than the cost of services you actually received.

A few services are not part of managed care. They include care in an ICF/IID or home care for people with intellectual disabilities through an HCBS waiver program operated by the Department of Intellectual and Developmental Disabilities. But TennCare still has to be paid back for that care too.

TennCare can't ask for the money back until **after** your death. TennCare can't ask for more money back than we paid for your care. (This includes payments to your health plan and the actual cost of services that aren't part of managed care.) And TennCare can't ask your family to pay for your care out of their own pockets.

TennCare may not have to get the money back from your estate if:

- You leave very little money or property when you die.
- Your care did not cost much.
- The things you left can't be used to pay people you owe through probate court. An example is life insurance money.

But these times do not happen by themselves. The person handling your things after you die must **get a "Release" from TennCare**. It says you don't owe TennCare money. If your things have to go through Probate court, the Release must be filed there.

Sometimes TennCare must let your money or property stay in the family longer.

These times are if you leave your money or property to:

- Your surviving husband or wife.
- Your child who is under age 21 when you die.
- Or your child of any age who is blind or permanently and totally disabled.

TennCare won't try to get repaid until this family member dies or the child turns age 21. But the person who handles your things must file the TennCare Release in Probate Court.

Sometimes TennCare must let just your HOME stay in the family longer.

This happens when one of these family members lives in the home when you die:

- Your surviving husband or wife.
- Your child who is under age 21 when you die.
- Your child of any age who is blind or permanently and totally disabled.
- Your child who lived in the home and took care of you if this care kept you out of a nursing home or home care for two years.
- Or your brother or sister who helped make the house payments if they lived there for a year before you got nursing home or home care.

By law, TennCare should not take the house until these family members die or the child turns 21. But the person who handles your things must file the TennCare Release in Probate Court.

TennCare may leave your money and property in the family because of undue hardship.

But the State does not do this very often. The family must prove that losing the money or property in your estate will cause an undue hardship. For example, if your property is a family farm and the family's only income, then the person handling your things can ask the State not to take the property. The State may or may not agree.

How will your family find out if your estate owes money to TennCare?

After you die, the law says that your estate must be used first to pay the debts you owe. What's left after your debts are paid is given to the people who should have it. This is called "probate." Your debts include any amount you must pay TennCare for care you received while you were living. The probate court cannot close your estate until your lawyer or executor of your estate gets a Release from TennCare. A Release says your estate doesn't owe TennCare any money.

To get a Release, the person must complete a Request for Release Form and send it to TennCare. It must include all of the proof that's asked for. TennCare will send a Release if:

- Your estate doesn't owe TennCare any money,
- OR, if you don't have to pay TennCare any money from your estate right now.

What if you do have to pay TennCare money from your estate? TennCare will file a claim against your estate. It will say the amount your estate must pay TennCare for care you received. That money must be paid by your estate before TennCare will provide a Release.

How to ask for a Release from TennCare

The person handling your things after you die may apply for a Release in one of three ways:

1. Get the Release online at https://tn.gov/assets/entities/tenncare/attachments/releaseform.pdf.

2. Get the Release from the Probate Court Clerk's office by asking for a "Request for Release from Estate Recovery."

3. Get the Release from TennCare by sending a letter or fax to:

Division of TennCare
Estate Recovery Unit
310 Great Circle Road
Nashville, TN 37243

Fax: 615-413-1941

All of the information asked for in the Release must be included. And they must provide any other information TennCare requests to decide if the Release will be given.

Do you have questions or need help with estate recovery?

- You can **call** TennCare for free at 1-866-389-8444.
- OR, you can **fax** TennCare at 615-413-1941.
- OR, you can **mail** TennCare at:

  Division of TennCare
  Estate Recovery Unit
  310 Great Circle Road
  Nashville, TN 37243

Abuse, neglect and exploitation

TennCare members in Employment and Community First CHOICES have the right to be free from abuse, neglect and exploitation. It's important that you understand how to identify and how to report abuse, neglect and exploitation.

Abuse can be...

- Physical abuse;
- Sexual abuse; or
- Emotional or psychological abuse.

It includes injury, unreasonable confinement, intimidation, or punishment that results in physical harm, pain or mental anguish. Abuse of all forms is a "knowing" or "willful" act.

Neglect is the failure to provide services and supports that are necessary to avoid physical harm, mental anguish or mental illness and that results in injury or probable risk of serious harm. Neglect may or may not be intended.

Exploitation means that someone's money or belongings are intentionally taken, misplaced or misused. Even if they are only taken for a short time or the person gave their consent, it may still be exploitation.

Exploitation can include ...

- Fraud or coercion;
- Forgery; or
- Unauthorized use of cash, bank accounts or credit cards.

If you think you're a victim of abuse, neglect or exploitation or that any other ECF CHOICES member is a victim of abuse, neglect or exploitation, please tell your Support Coordinator. Support Coordinators and providers must report any suspected case of abuse, neglect or exploitation to the Department of Intellectual and Developmental Disabilities (DIDD).

You, your family, people who support you or any private citizen may report suspected abuse, neglect or exploitation directly to the DIDD Investigations Unit 24 hours a day.

The number to call depends on where you live. The toll-free numbers for each region are:

East Tennessee	**1-800-579-0023**
Middle Tennessee	**1-888-633-1313**
West Tennessee	**1-888-632-4490**

You don't have to tell them who you are when you report. DIDD will work with law enforcement as needed, and with Adult Protective Services and Child Protective Services.

Do you have a mental illness and need help with this information? The TennCare Partners Advocacy Line can help you. Call them for free at **1-800-758-1638**.

If you have a hearing or speech problem, you can call us on a TTY/TDD machine. **Our TRS number is 711.**

Section 3. What services are covered outside of the plan?

Section 3.1

Services *not* covered by the plan

There are services that are not covered by Amerivantage Full Dual Coordination (HMO D-SNP) but are available through Medicaid. If you have questions about the Medicaid assistance you get please review your *Medicaid Member Handbook* or contact your state Medicaid office at the phone number listed in Chapter 2, Section 6 of this document.

Section 4. What services are not covered by the plan?

Section 4.1

Services *not* covered by the plan (exclusions)

This section tells you what services are "excluded."

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
You are enrolled in a Dual Special Needs Plan. Some services that are not covered under the Original Medicare Program may be covered under any Medicaid Benefits you are entitled to. Your Medicaid coverage is determined by the state in accordance with your aid category. Should you require a service that is not a Medicare covered service, we can help you coordinate your care to identify any Medicaid coverage or resources available to you.	✓	
Services considered not reasonable and necessary, according to Original Medicare standards	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Full-time nursing care in your home.	✓	
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		✓ This plan may cover Homemaker services that is offered as a supplemental benefit, if specified in the Chapter 4 Benefit Chart. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. If the benefit is available you must use a provider who participates in our contracted network.
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Routine dental care, such as cleanings, fillings or dentures.		✓ Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. This plan may cover routine dental care if specified in the Chapter 4 Benefit Chart as a supplemental benefit or purchased as part of an optional supplemental benefit package. If your plan offers a dental allowance, cosmetic services, such as teeth whitening, braces, dental jewelry, tooth colored filings/crowns, veneers, etc., are not covered. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit you must use a provider who participates in our routine dental Vendor network. Please contact Customer Service to locate a provider that is within that dental vendors network.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Dental services are excluded from coverage in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, except for inpatient or outpatient hospital services required because of a medical condition. Additionally, some dental services are covered if an integral part of a covered medical procedure. Medicare has specific guidelines for covered services. Contact Customer Service for more information on these limited services.
Routine chiropractic care including x-rays, physical therapy, nutrients, office visits		✓ Manual manipulation of the spine to correct a subluxation is covered, if medically necessary, when provided by a chiropractor or another qualified provider. Medicare doesn't cover routine chiropractic care. This plan may cover routine chiropractic care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine chiropractic provider network. Contact Customer Service for more information on these limited services.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Medicare covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, and heel spurs), but generally doesn't cover routine foot care (like the cutting or removal of corns and calluses, the trimming, cutting, and clipping of nails, flat foot, or hygienic or other preventive maintenance, including cleaning and soaking the feet). This plan may cover additional routine foot care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine podiatry provider network. Contact Customer Service for more information on these limited services.
Home-delivered meals		✓ Medicare doesn't cover home-delivered meals. This plan may cover home-delivered meals if specified in the Chapter 4 Benefit Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our network. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. Contact Customer Service for more information on any supplemental benefit offered.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Orthopedic shoes or supportive devices for the feet		✓ Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes are for people with diabetic foot disease.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Medicare doesn't cover routine hearing exams, hearing aids, or exams for fitting hearing aids. This plan may cover routine hearing care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. In addition, supplemental benefit hearing aids are limited to the list of covered devices and custom or alternative devices are not covered. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit you must use a provider who participates in our routine hearing vendor network. Please contact Customer Service to locate a provider that is within that hearing vendors network.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, refraction vision tests and other low vision aids.		✓ Medicare doesn't cover routine eye exams, eyeglasses or contact lenses. However, an eye exam and one pair of eyeglasses (or contact lenses) are covered by Medicare for people after cataract surgery, that implants an intraocular lens. Medicare coverage of post cataract eyeglasses is limited to standard lenses and standard frames only. Scratch resistant coating, mirror coating, polarization, deluxe lens feature, progressive lenses, polycarbonate (or similar material), high index glass or plastic (light weight or thinness), specialty occupational multifocal lenses, tinted lenses, including photochromatic lenses used as sunglasses, eyeglass cases and deluxe frames are not covered by Medicare. If these items are purchased, you will be responsible for the cost. Anti-reflective coating, tints, oversized lenses or polycarbonate or Trivex™ must be medically necessary and reasonable to be covered based on Medicare criteria. In addition to the Medicare coverage, this plan may cover routine eye exams and eyewear if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Refraction vision test is not covered except where covered under supplemental routine eye exam benefit. This is a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine vision provider network.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture		✓ Available Medicare covers acupuncture for lower chronic back pain under certain circumstances. This plan may cover additional acupuncture if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit you must use a provider who participates in our Acupuncture network. Please contact Customer Service to locate a provider that is in the network.
Naturopath services (uses natural or alternative treatments).	✓	
Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Over-the-counter purchases		✓ Medicare doesn't cover Over-the-counter purchases. This plan may cover over-the-counter purchases if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. If the benefit is available you must utilize the contracted OTC provider, limitations and exclusions may apply.
Wigs (even if needed due to a covered medical condition).	✓	
Providers who are prohibited from being covered under the Medicare program for any reason.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Worldwide Care		✓ Medicare generally doesn't cover health care while you're traveling outside the U.S. and its territories. There are some exceptions offered in limited circumstances as per Medicare guidelines. This plan may cover health care you get while traveling outside the U.S. if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. This benefit applies to travel outside the United States and its territories for less than six months. Members are responsible for all costs that exceed the benefit limitation as well as all costs to return to the service area. If benefit available, coverage is limited to amount noted on benefit summary per year for all covered services rendered outside the US or its territories.
Prescription drugs you buy outside the U.S.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Services performed by out-of-network providers.		✓ You are responsible for verifying provider network status prior to receiving services. In-network providers and facilities are listed in the Provider Directory or online at the website listed on the back cover of this booklet. The use of an out-of-network provider for services not considered urgent/emergent (required immediately) or approved in advance may not be covered by the plan. Please see Chapter 3, Section 2.4 for more information.
Services performed by non-participating vendor network providers.		✓ Some supplemental benefits utilize a specific Vendor and providers who participate with that Vendor when noted in the Chapter 4 Benefit Chart. Providers that participate with the plan may or may not be associated with that Vendor. You may call the plan prior to services being rendered with any questions. To be covered in-network, you must use a provider that participates with that Vendor as identified in the provider directory. There may be other exceptions, see Chapter 3 (Using the plan for your medical services) for more information.
Services ordered or administered that are determined to not be a Medicare covered benefit in accordance with Medicare guidelines and the Social Security Act.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Lab, Radiological & Genetic Testing		✓ We follow Medicare guidelines when determining if Lab, Radiological & Genetic Testing services are covered, even if ordered by a physician. Not all lab, radiological or genetic testing is covered under the Medicare Program. You have the right to contact the plan prior to services being rendered to determine if the services will be covered for your condition (see Organization Determination).
Non-emergency ambulance trips		✓ Medicare does not pay for transportation, including non-emergency ambulance transportation to and from dialysis, unless the Medicare definition of bed-confined is met and documented by your doctor. Bed-confined is defined as unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair.
Transportation (that Medicare does not cover such as trips to a physician's office) regardless of the member's condition.		✓ Medicare doesn't cover this service. This is considered excluded by statute or a benefit exclusion that is not covered under the Original Medicare program. This plan may cover Transportation if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. If the benefit is available you must use a provider who participates in our contracted Transportation network.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Modifications to a member's home such as a stair lift and other devices including bathtub grab bars, special pillows, chairs and other items that do not fall under Medicare-covered durable medical equipment.		✓ This plan may cover Assistive Devices that is offered as a supplemental benefit if specified in the Chapter 4 Benefit Chart. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. If the benefit is available you must use a provider who participates in our contracted network.
Items and services administered to a beneficiary for the purpose of causing or assisting in causing death.	✓	
Items and services required as a result of war.	✓	
Items and services authorized or paid by a government entity such as Veterans Administration authorized services.	✓	
Defective equipment or medical devices covered under warranty.	✓	

Chapter 5

Using the plan's coverage for Part D prescription drugs

How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, some information in this Evidence of Coverage about the costs for Part D Prescription drugs may not apply to you.

We send you a separate insert, called the *"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also known as the *"Low Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the *"LIS Rider."* (Phone numbers for Customer Service are printed on the back cover of this document.)

Section 1. Introduction

This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits.

Section 1.1

Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.)*
- Your drug must be on the plan's *List of Covered Drugs (Formulary).* We call it the "*Drug List*" for short. (See Section 3, *Your drugs need to be on the plan's "Drug List.")*
- Your drug must be used for a medically accepted indication. "Medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

Section 2. Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1

Use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are on the plan's *Drug List.*

Section 2.2

Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider/Pharmacy Directory*, visit our website (https://shop.amerigroup.com/medicare) and/or call Customer Service.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Service or use the *Provider/Pharmacy Directory.*

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Our plan will cover home infusion therapy if:
  - Your prescription drug is on our plan's formulary or a formulary exception has been granted for your prescription drug.
  - Your prescription drug is not otherwise covered under our plan's medical benefit.
  - Our plan has approved your prescription for home infusion therapy.
  - Your prescription is written by an authorized prescriber.

  Please refer to your *Provider/Pharmacy Directory* to find a home infusion pharmacy provider in your area. For more information, call Customer Service.
- Pharmacies that supply drugs for residents of a long-term-care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination or education on their use. (***Note***: This scenario should rarely happen.)

To locate a specialized pharmacy, look in your *Provider/Pharmacy Directory* or call Customer Service.

Section 2.3

Using the plan's mail-order service

Our plan's mail-order service requires you to order ***at least* a 30-day supply of the drug and *no more than* a 100-day supply.**

To get order forms and information about filling your prescriptions by mail, call our mail-order Customer Service at 1-833-203-1735. TTY users should call 711. Hours are 24 hours a day, 7 days a week. Our Interactive Voice Response (IVR) Service is available 24 hours a day, seven days a week.

Usually a mail-order pharmacy order will get to you in no more than 14 days. Pharmacy processing time will average about two to five business days; however, you should allow additional time for postal service delivery. It is advisable for first-time users of the mail-order pharmacy to have at least a 30-day supply of medication on hand when a mail-order request is placed. If the prescription order has insufficient information, or if we need to contact the prescribing physician, delivery could take longer.

It is advisable for first-time users of the mail-order pharmacy to ask the doctor for two signed prescriptions:

- One for an initial supply to be filled at their local retail participating pharmacy.
- The second for up to a three-month supply with refills to send to the mail-order pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office:

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by providing consent on your first new home delivery prescription, sent in by your physician.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling the Customer Service phone number on your membership card.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay or cancel the new prescription.

Refills on mail-order prescriptions:

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program, but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 30 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling the Customer Service phone number on your membership card.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4

How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an "extended supply") of maintenance drugs on our plan's *Drug List*. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5

When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Please check first with Customer Service to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drugs at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You are traveling within the United States and its territories and become ill, or lose or run out of your prescription drugs.
- You are traveling within the United States and its territories and the prescription is for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug that is not regularly stocked at an accessible network retail pharmacy. (For example, an orphan drug or other specialty pharmaceutical.)

In these situations, please check first with Customer Service to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 6 Section 2 explains how to ask the plan to pay you back.)

Section 3. Your drugs need to be on the plan's *"Drug List"*

Section 3.1

The "*Drug List*" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "*Drug List*" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The *Drug List* includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits.

We will generally cover a drug on the plan's *Drug List* as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.)
- Or, supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The *Drug List* includes brand-name drugs and generic drugs.

A brand-name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand-name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the *Drug List*, when we

refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand-name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand-name drugs and some biological products.

What is *not* on the *Drug List?*

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more information about this, see Section 7.1 in this chapter.)
- In other cases, we have decided not to include a particular drug on the *Drug List*. In some cases, you may be able to obtain a drug that is not on the *Drug List*. For more information, please see Chapter 8.
- The *Drug List* does not include prescription drugs that are only covered by Medicaid. Please contact your state Medicaid agency for information about prescription drugs covered by Medicaid.

Section 3.2

There are six "cost-sharing tiers" for drugs on the *Drug List*

Every drug on the plan's *Drug List* is in one of six cost-sharing tiers.

- Tier 1 includes preferred generic drugs.
- Tier 2 includes generic drugs.
- Tier 3 includes preferred brand drugs.
- Tier 4 includes nonpreferred drugs.
- Tier 5 includes specialty drugs.
- Tier 6 includes select care drugs for diabetic, blood pressure, cholesterol conditions and osteoporosis.

To find out which tier your drug is in, look it up in the plan's *Drug List.*

Section 3.3

How can you find out if a specific drug is on the *Drug List*?

You have three ways to find out:

1. Check the most recent *Drug List* we provided electronically.
2. Visit the plan's website (www.amerigroup.com/medicare). The *Drug List* on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's *Drug List* or to ask for a copy of the list.

Section 4. There are restrictions on coverage for some drugs

Section 4.1

Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the *Drug List*. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our drug list. This is because the same drugs can differ based on the strength, amount or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg;

one per day versus two per day; tablet versus liquid).

Section 4.2

What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8.)

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version instead of the brand-name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you or has written "no substitutions" on your prescription for a brand-name drug, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly, but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy.**"

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 5. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1

There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions.

For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered, but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.

There are things you can do if your drug is not covered in the way that you'd like it to be covered.

- If your drug is not on the *Drug List* or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2

What can you do if your drug is not on the *Drug List* or if the drug is restricted in some way?

If your drug is not on the *Drug List* or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's *Drug List*** OR **is now restricted in some way.**

- **If you are a new member,** we will cover a temporary supply of your drug during the first 90 days of your membership in the plan
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term-care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days, reside in a long-term-care facility and need a supply right away:** We will cover one 34-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's *Drug List*. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 6. What if your coverage changes for one of your drugs?

Section 6.1

The *Drug List* can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the *Drug List.*

For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand-name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's *Drug List.*

Section 6.2

What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the *Drug List* occur, we post information on our website about those changes. We also update our online *Drug List* on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand-name drug on the *Drug List* (or we change the tier or add new restrictions to the brand-name drug or both)**
  - We may immediately remove a brand-name drug on our *Drug List* if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower tier and with the same or fewer restrictions. We may decide to keep the brand-name drug on our Drug List, but immediately move it to a higher tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
  - If you are taking the brand-name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand-name drug. You may not get this notice before we make the change.
  - You or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 8.
- **Unsafe drugs and other drugs on the *Drug List* that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the *Drug List*. If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the *Drug List***
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 8.

Changes to the *Drug List* that do not affect you during this plan year

We may make certain changes to the *Drug List* that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the *Drug List.*

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand-name drug or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

Section 7. What types of drugs are *not* covered by the plan?

Section 7.1

Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 8.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Contact your state Medicaid office for more information on what is covered under your state's Medicaid program (phone numbers are in Chapter 2, Section 6).

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms

- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- For more information about Medicaid benefits, call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 8. Filling a prescription

Section 8.1

Provide your membership information

To fill your prescription, provide your plan membership card at the network pharmacy you choose.

When you show your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

If your prescription is not covered under the plan, you may have coverage under your Medicaid benefits. Please provide the pharmacy with your Medicaid card to fill prescriptions not covered under the Medicare Part D prescription drug benefit.

Section 8.2

What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 6, Section 2 for information about how to ask the plan for reimbursement.)

Section 9. Part D drug coverage in special situations

Section 9.1

What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2

What if you're a resident in a long-term-care (LTC) facility?

Usually, a long-term-care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the

facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider/Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term-care (LTC) facility and need a drug that is not on our *Drug List* or is restricted in some way

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3

What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g. antinausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide the notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

Section 10. Programs on drug safety and managing medications

Section 10.1

Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis.

During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.
- Unsafe amounts of opioid pain medications.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2

Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had

a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 8 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care or live in a long-term-care facility.

Section 10.3

Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you

have any questions about this program, please contact Customer Service.

Section 11. We send you reports that explain payments for your drugs and which payment stage you are in

Section 11.1

We send you a monthly summary called the *Part D Explanation of Benefits* (the "*Part D EOB*")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next.

In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf, plus the amount paid by the plan.

Our plan will prepare a written summary called the *Part D Explanation of Benefits* (it is sometimes called the "*Part D EOB*") when you have had one or more prescriptions filled through the plan during the previous month. The *Part D EOB* provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options.

The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost sharing for each prescription claim that may be available.

Section 11.2

Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies.

Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost for the drug. For instructions on how to do this, go to Chapter 6, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the *Part D Explanation of Benefits (a Part D EOB)* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Chapter 6

Asking us to pay a bill you have received for covered medical services or drugs

Section 1. Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid or medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost for the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes and ask you to pay more than your share of the cost.

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. We do not allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact

the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. You should ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this document, has information about how to make an appeal.

Section 2. How to ask us to pay you back or to pay a bill you have received

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you received the service, item or drug.

To make sure you are giving us all the information we need to make a decision, you can

fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster. With your request include:
  - Itemized bill with dates of service and amount charged for each service.
  - Receipt of payment.
  - Medical records (if the medical records are not written in English, a certified translation of the documents should be provided if available).
  - Itinerary (if the services were received on a cruise ship).
  - Appointment of Representation (AOR) or Power of Attorney form (if someone other than the member is submitting the request.)
- Either download a copy of the form from our website https://shop.amerigroup.com/medicare or call Customer Service and ask for the form.

Mail your request for payment for medical services, together with any bills or paid receipts to us at this address:

Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

Mail your request for payment **for Part D prescription drugs**, together with any bills or receipts, to us at this address:
CarelonRx
Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

Section 3. We will consider your request for payment and say yes or no

Section 3.1

We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2

If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 8 of this document.

Chapter 7

Your rights and responsibilities

Section 1. Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1

We must provide information in a way that works for you and consistent with your cultural sensitivities (In languages other than English, in braille, in large print or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and nonclinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in 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 Customer Service.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

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 us at 1-833-713-1074. (TTY 711) or by writing us at: Civil Rights Coordinator, 4361 Irwin-Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. 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 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2

We must ensure that you get timely access to your covered services and drugs

You have the right to choose a Primary Care Provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8, Section 5 tells what you can do.

Section 1.3

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations, typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

Below is the Notice of Privacy Practices as of June 2022.

Notice of privacy practices

Important information about your rights and our responsibilities

Protecting your personal health information is important. Each year, we're required to send you specific information about your rights and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

Would you like to go paperless and read this online or on your mobile app? Go to **www.amerigroup.com/medicare** and sign up to get these notices by email.

State notice of privacy practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give additional rights to limit sharing your health information. Please call the Customer Service phone number on your ID card for more details.

Your personal information

Your nonpublic (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company — without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

THIS NOTICE DESCRIBES HOW MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE READ CAREFULLY.

HIPAA notice of privacy practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your protected health information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay claims for health care you get through your plan.

Health care operations: We collect, use and share PHI for our health care operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations, visit

www.amerigroup.com/privacy for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways — usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medicines
  - Reporting suspected abuse, neglect or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing worker's compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity, language, sexual orientation and gender identity: We may receive race, ethnicity, language, sexual orientation and gender identity information about you and protect this information as described in this

notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity, language, sexual orientation and gender identity information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.
- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.
- Call Customer Service at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and information practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater impact of other privacy protections. As a result, if any state or federal privacy law requires us to give you applicable laws more privacy protections, then we must follow that law in addition to HIPAA.

To see more information

To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy web page at **www.amerigroup.com/privacy**.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call **1-844-203-3796** to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Customer Service phone number on your ID Card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting hhs.gov/ocr/privacy/hipaa/complaints/. We will not take action against you for filing a complaint.

Contact information

You may call us at the Customer Service phone number on your ID card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

You'll pay your usual deductible, copay and/or coinsurance. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra.

Section 1.4

We must give you information about the plan, its network of providers and your covered services

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.**You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapter 3 and Chapter 4 provide information regarding medical services. Chapter 5 provides information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 8 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 8 also provides information on asking us to change a decision, also called an appeal.

Section 1.5

We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand.* You also have the right to participate fully in decisions about your health care.

To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation.

This means that, *if you want to*, you can:

- Fill out a written form to **give someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and

"power of attorney for health care" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the TennCare.

Section 1.6

You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns or complaints and need to request coverage, or make an appeal, Chapter 8 of this document tells what you can do.

Whatever you do – ask for a coverage decision, make an appeal or make a complaint – **we are required to treat you fairly.**

You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

Section 1.7

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697), or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service**.
- You can **call the SHIP.** For details, go to Chapter 2, Section 3.

- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. (TTY 1-877-486-2048).

Section 1.8

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service**.
- You can **call the SHIP.** For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. (TTY 1-877-486-2048).

Section 2. You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapter 3 and Chapter 4 give the details about your medical services.
  - Chapter 5 gives the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move within our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move outside of our plan service area, you cannot remain a member of our plan.**
- **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 8

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 1. Introduction

Section 1.1

What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints;** also called grievances.

Each process has a set of rules, procedures and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.2

What about the legal terms?

There are legal terms for some of the rules, procedures and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain Legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “integrated organization determination” or “coverage determination” or "at-risk determination," and “independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Section 2. Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Customer Service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You also can visit the Medicare website (www.medicare.gov).

You can get help and information from Medicaid

In Tennessee:
TennCare

Call: 1-800-342-3145

TTY: 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: TennCare
310 Great Circle Road
Nashville, TN, 37243

Section 3. Understanding Medicare and Medicaid complaints and appeals in our plan

You have Medicare and get assistance from Medicaid. Information in this chapter applies to **all** of your Medicare and Medicaid benefits. You do not have to use one process for your Medicare benefits and a different process for your Medicaid benefits. This is sometimes called an "integrated process" because it integrates Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4** of this chapter, "Step-by-step: How a Level 2 appeal is done."

Problems about your benefits

Section 4. Coverage decisions and appeals

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid.**

Is your problem or concern about your benefits or coverage? (This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered and problems related to payment for medical care or prescription drugs.)	
Yes	**No**
Go on to the next section of this chapter, **Section 5.1, "A guide to the basics of coverage decisions and appeals."**	Skip ahead to **Section 9.1** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

Section 5. A guide to the basics of coverage decisions and appeals

Section 5.1

Asking for coverage decisions and making appeals: The big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor

makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, your appeal will automatically go on to Level 2. The Level 2 appeal is conducted by an Independent Review Entity that is not connected to us.

- Your case will be automatically sent to the independent review organization for a Level 2 appeal – you do not have to do anything. The independent review organization will mail you a notice to confirm they received your Level 2 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the Level 2 appeal, you may be able to continue through additional levels of appeal. (Section 10 in this chapter explains the Level 3, 4 and 5 appeals processes.)

Section 5.2

How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

- For medical care, your doctor or health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other health care provider, or other person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf. The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3

Which section of this chapter gives the details for *your* situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter, "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter, "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 8** of this chapter, "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 9** of this chapter, "How to ask us to keep covering certain medical services if you think your coverage is ending too soon. (This section only applies to these services: home health care, skilled nursing facility care and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations, such as your SHIP.

Section 6. Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (What is covered).* To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2

Step-by-step: How to ask for a coverage decision

Legal Terms	When a coverage decision involves your medical care, it is called an **"organization determination."** A "fast coverage decision" is called an **"expedited determination."**

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision only if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires**

that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines
- Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
- Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug,** we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days.** If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint". (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want.
- If you make an appeal, it means you are going on to Level 1 of the appeals process

Section 6.3

Step-by-step: How to make a Level 1 appeal

Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."** A "fast appeal" is also called an **"expedited reconsideration."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- If you are asking for a standard appeal, submit your standard appeal in writing.
- If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar**

days if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard" appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within seven calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should **not** take extra days, you can file a "fast complaint" you file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within seven calendar** days if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4

Step-by-Step: How a Level 2 appeal is done

Legal Term	The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government

agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 203 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- For the "fast appeal," the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- For the "standard appeal," if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal.
- If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within seven calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug under dispute **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
  - Explaining its decision
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
  - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter tells more about the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: You can ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services that are usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal,** they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

Section 6.5

What if you are asking us to pay you back for a bill you have received for medical care?

We can't reimburse you directly for a Medicaid service or item. If you get a bill for Medicaid-covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking to be paid back for something you have already paid for:

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill for *Medicaid* covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the health care provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost within 60 calendar days after we receive your request.
  - If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we will send your health care provider the payment for the cost within 60 calendar days after we receive your request.
  - Then you will need to contact your health care provider to get them to pay you back. If you haven't paid for the services, we will send the payment directly to the health care provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down**, you can make an appeal.** If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 6.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 30 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the independent review organization decides we should pay, we must send you or the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

Section 7. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1

This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5, for more information about a medically accepted indication.) For details about Part D drugs, rules and restrictions, see Chapter 5.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "*Drug List*" instead of "*List of Covered Drugs*" or "*Formulary*."
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms	An initial coverage decision about your Part D drugs is called a "**coverage determination.**"

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2

What is an exception?

Legal Terms	Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a **"tiering exception."**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain

the medical reasons why you need the exception approved.

Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *Drug List*.**

2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our *Drug List.*

Section 7.3

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our *Drug List* includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4

Step-by-step: How to ask for a coverage decision, including an exception

Legal Terms	A "fast coverage decision" is called an **"expedited coverage determination."**

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

"Standard coverage decisions" are made within **72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision." To get a fast coverage decision, you must meet two requirements:

- You must be asking for a *drug you have not yet received.* (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.

- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and we give you our answer.

Deadlines for a "fast coverage decision"

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested** we must provide the coverage

within 72 hours after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we **will** send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to request an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 7.5

Step-by-step: How to make a Level 1 appeal

Legal Term	An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**
	A "fast appeal" is also called an **"expedited redetermination."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within seven days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 1-833-713-1074 (TTY 711). Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good

cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information**. You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision**.**

Deadlines for a "standard" appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within seven calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within seven calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains Level 2 appeal process.
- **If our answer is yes to part or all of what you requested** we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than **seven calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6

Step-by-step: How to make a Level 2 appeal

Legal Term	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast appeal"

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard appeal"

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within seven calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For "fast appeals"

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For "standard appeals"

- **If the independent review organization says yes to part or all of what you requested,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Levels 3, 4 and 5 appeals.

Section 8. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your **"discharge date."**
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1

During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice.

If you do not get the notice, from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service or 1–800–MEDICARE (1–800–633–4227), 24 hours a day, seven days a week (TTY 1–877–486–2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay

- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to dischare you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not** mean you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 8.2

Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.

- If you do **not** meet this deadline and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see **Section 8.4** of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a Detailed Notice of Discharge. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the Detailed Notice of Discharge by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says no, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.3

Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.
- **Section 10** of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4

What if you miss the deadline for making your Level 1 appeal?

Legal Terms	A “fast review” (or “fast appeal”) is also called an **“expedited appeal.”**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 alternate appeal

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.

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

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

Step-by-Step: Level 2 alternate appeal process

Legal Term	The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization** is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

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

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to

pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- **Section 10** of this chapter tells more about the process of Levels 3, 4 and 5 appeals.

Section 9. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1

This section is only about three services*:* Home health care, skilled nursing facility care and comprehensive outpatient rehabilitation facility (CORF) services

When you are getting **home health services, skilled nursing care, or rehabilitation care (comprehensive outpatient rehabilitation facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the costs** *for your care***.**

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 9.2

We will tell you in advance when your coverage will be ending

Legal Terms "**Notice of Medicare Non-Coverage"** It tells you how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing a**t least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does *not* mean you agree** with the plan's decition to stop care.

Section 9.3

Step-by-Step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care received for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: Contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.

Your deadline for contacting this organization

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5 of this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms	This notice explanation is called the **"Detailed Explanation of Non-Coverage."**

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the ***Detailed Explanation of Non-Coverage*** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal **and** you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 9.4

Step-by-Step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

Section 9.5

What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 alternate appeal

Legal Terms	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review"

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

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

Legal Term	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step-by-Step: Level 2 alternate appeal process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. **Section 11** of this chapter tells how to make a complaint.)

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

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

Section 10. Taking your appeal to Level 3 and beyond

Section 10.1

Appeal Levels 3, 4 and 5 for medical service requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal - An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal - The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal - A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2

Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3

Appeal Levels 3, 4 and 5 for Part D drug requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal - An Administrative Law Judge or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal - The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal - A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 11. How to make a complaint about quality of care, waiting times, customer service or other concerns

Section 11.1

What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	▪ Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	▪ Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service or other negative behaviors	▪ Has someone been rude or disrespectful to you? ▪ Are you unhappy with our Customer Service? ▪ Do you feel you are being encouraged to leave the plan?
Waiting times	▪ Are you having trouble getting an appointment, or waiting too long to get it? ▪ Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? □ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	▪ Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	▪ Did we fail to give you a required notice? ▪ Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: ▪ You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no, you can make a complaint. ▪ You believe we are not meeting the deadlines for coverage decisions or appeals, you can make a complaint. ▪ You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved, you can make a complaint. ▪ You believe we failed to meet required deadlines for forwarding your case to the independent review organization, you can make a complaint.

Section 11.2

How to make a complaint

Legal Terms

- A **"complaint"** is also called a **"grievance."**
- **"Making a complaint"** is also called **"filing a grievance."**
- **"Using the process for complaints"** is also called **"using the process for filing a grievance."**
- A **"fast complaint"** is also call an **"expedited grievance."**

Section 11.3

Step-by-Step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- **Whether you call or write, you should contact Customer Service right away.** You can make the complaint at any time after you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4

You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.5

You can also tell Medicare about your complaint

You can submit a complaint about Amerivantage Full Dual Coordination (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1–800–MEDICARE (1–800–633–4227). TTY/TDD users can call 1–877–486–2048.

Chapter 9

Ending your membership in the plan

Section 1. Introduction to ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

Section 2. When can you end your membership in our plan?

Section 2.1

You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- **C**hoose any of the following types of Medicare plans:
  - Another Medicare health plan with or without prescription drug coverage.
  - 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.
  - ***Note:*** If you disenroll from Medicare prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late-enrollment penalty if you join a Medicare drug plan later.
  - Contact your state Medicaid office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2

You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the

"Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from October 15 to December 7.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - ☐ Another Medicare health plan, with or without prescription drug coverage.
  - ☐ Original Medicare with a separate Medicare prescription drug plan.
    OR
  - ☐ Original Medicare without a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when you new plan's coverage begins on January 1.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3

You can end your membership during the Medicare Advantage Open Enrollment Period

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

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - ☐ Switch to another Medicare Advantage plan with or without prescription drug coverage.
  - ☐ Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4

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

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

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples. For the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - Usually, when you have moved
  - If you have Medicaid
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions

- If we violate our contract with you
- If you are getting care in an institution, such as a nursing home or long-term-care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period,** please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

  ☐ Another Medicare health plan with or without prescription drug coverage.

  ☐ Original Medicare *with* a separate Medicare prescription drug plan.

  OR

  ☐ Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late-enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: 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.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5

Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service**.
- Find the information in the ***Medicare & You 2023 handbook***.
- Contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. (TTY 1-877-486-2048).

Section 3. How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
▪ Another Medicare health plan	▪ Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month.

If you would like to switch from our plan to:	This is what you should do:
	▪ You will automatically be disenrolled from our plan when your new plan's coverage begins.
▪ Original Medicare *with* a separate Medicare prescription drug plan	▪ Enroll in the new Medicare prescription drug plan at any time. Your new coverage will begin on the first day of the following month. ▪ You will automatically be disenrolled from our plan when your new plan's coverage begins.
▪ Original Medicare *without* a separate Medicare prescription drug plan ☐ 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. ☐ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late-enrollment penalty if you join a Medicare drug plan later.	▪ **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this. ▪ You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. ▪ You will be disenrolled from our plan when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late-enrollment penalty if you join a Medicare drug plan later.

For questions about your TennCare benefits, contact:

Call: 1-800-342-3145 8:00 a.m. - 5:00 p.m. Monday through Friday

TTY: 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: TennCare
310 Great Circle Road
Nashville, TN 37243

Website: https://www.tn.gov/tenncare

Ask how joining another plan or returning to Original Medicare affects how you get your TennCare coverage.

Section 4. Until your membership ends, you must keep getting your medical services and drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network or mail-order pharmacies to get your prescriptions filled**.

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

Section 5. Our plan must end your membership in the plan in certain situations

Section 5.1

When must we end your membership in the plan?

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

- If you no longer have Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call **Customer Service**.

Section 5.2

We *cannot* ask you to leave our plan for any health-related reason

We are not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 5.3

You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

Chapter 10

Legal notices

Section 1. Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

Section 2. Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act and all other laws that apply to organizations that get federal funding and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3. Notice about Medicare secondary payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Amerivantage Full Dual Coordination (HMO D-SNP), as a Medicare Advantage organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4. Additional legal notices

Collecting member payments

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this Evidence of Coverage are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

In the event that a service is rendered for which you are billed, you have at least 12 months from the date of service to submit such claims to your plan. According to CMS Pub 100-02 Benefit Policy, Chapter 15, Section 40, physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they **are not allowed to**

charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished. However, a physician or practitioner (as defined in §40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services.

You may submit such claims to:
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

Entire contract

This Evidence of Coverage and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of Amerigroup, has authority to waive any conditions or restrictions of this Evidence of Coverage or the Medical Benefits Chart in Chapter 4.

No change in this Evidence of Coverage shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Cessation of operation

In the event of the cessation of operation or dissolution of your plan in the area in which you reside, this Evidence of Coverage will be terminated. You will receive notice 90 days before the Evidence of Coverage is terminated.

Please note: If the Evidence of Coverage terminates, your coverage will also end.

In that event, the company will explain your options at that time. For example, there may be other health plans in the area for you to join if you wish. Or, you may wish to return to Original Medicare and possibly obtain supplemental insurance. In the latter situation, Amerigroup would arrange for you to obtain, without health screening or a waiting period, a supplemental health insurance policy to cover Medicare coinsurance and deductibles.

Whether you enroll in another prepaid health plan or not, there would be no gap in coverage.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than 3 years after the service upon which the legal action is based was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from a non-network provider instead of a network provider. Your plan will reimburse you up to the amount that would have been covered under this Evidence of Coverage.
- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the Evidence of Coverage. This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service at 1-833-713-1074 or, if you are hearing or speech impaired and have a TTY telephone line, 711. The Customer Service department is available from 8:00 a.m. to 8:00 p.m, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your health care in case you become unable to make your own health care decisions.)

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would want and not want if you were not able to make decisions for yourself.
- You might want to do both - to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 2 of this booklet tells how to contact your SHIP. SHIPs have different names depending on which state you are in.

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state Department of Health.

Continuity and coordination of care

Amerigroup has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, Amerigroup helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.
- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.
- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved,

and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.

- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

Presidential or governor emergencies

In the event of a Presidential or Governor emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, your plan will make the following exceptions to assure adequate care during the emergency:

- Approve services to be furnished at specified noncontracted facilities that are considered Medicare-certified facilities;
- Temporarily reduce cost sharing for plan-approved out-of-network services to the in-network cost-sharing amounts; and
- Waive in full the requirements for a primary physician referral where applicable.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, your plan will resume normal operations 30 days from the initial declaration. When a disaster or emergency is declared, it is specific to a geographic location (i.e., county). Your plan will apply the above exceptions only if you reside in the geographic location indicated.

Chapter 11

Definitions of important words

Chapter 11. Definitions of important words

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D drug benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,400 on covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

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

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2)

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances and appeals.

Daily Cost-Sharing Rate – a "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: if your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Dual-Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you are a pregnant woman, loss of an

unborn child), loss of a limb or loss of function of a limb or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate or stabilize an emergency medical condition.

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a nonpreferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A member who has six months or fewer to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Coverage Limit – The maximum limit of coverage under the initial coverage stage.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached $4,660.

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

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility and/or facilities approved by CMS that furnishes similar long-term healthcare services that are covered under Medicare Part A, Medicare Part B or Medicaid, and whose residents have similar needs and healthcare status to the other named

facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Late-Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late-enrollment penalty.

If you ever lose your low-income subsidy ("Extra Help"), you must maintain your Part D coverage or you could be subject to a late-enrollment penalty if you ever choose to enroll in Part D in the future.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low-Income Subsidy – See "Extra Help."

Managed Long Term Services And Supports (MLTSS) – A program that provides home and community based services for members that require the level of care typically provided in a nursing facility, and allows them to receive necessary care in a residential or community setting. MLTSS services include (but are not limited to): assisted living services; cognitive, speech, occupational and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and nonmedical transportation. MLTSS is available to members who meet certain clinical and financial requirements.

Maximum Out-of-Pocket Amount – The most that you pay out of pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a three-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these

types of plans, a Medicare Advantage HMO or PPO plan, can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage plans with prescription drug coverage.**

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the coverage gap stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-covered services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **"Network providers"** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate, as well as provide, covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

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

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members

of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned or operated by our plan.

Out-of-Pocket Costs – See the definition for "Cost Sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – See *"Medicare Advantage (MA) Plan."*

Part D – The voluntary Medicare prescription drug benefit program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late-Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late-enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

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

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible, or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-713-1074. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-713-1074. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-713-1074。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-713-1074。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-713-1074. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-713-1074. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-713-1074 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-713-1074. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-713-1074번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика,

позвоните нам по телефону 1-833-713-1074. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: **إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري ليس عليك سوى الاتصال بنا على 1-833-713-1074. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.**

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Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-713-1074. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-713-1074. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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