Amerigroup RealSolutions®
Medicare Advantage Plans

Summary of Benefits

for Amerivantage Classic (HMO) and Amerivantage Select (HMO)

Available in Harris county, TX

AMERIGROUP Texas, Inc. is an HMO plan with a Medicare contract. Enrollment in AMERIGROUP Texas, Inc. depends on contract renewal.

Y0114_16_24693_U_034 CMS Accepted 10/01/2015

54099MUSENMUB_034
H5817_020-001_023-000_TX-HMO

Summary of Benefits

January 1, 2016 - December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Amerivantage Classic (HMO) and Amerivantage Select (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Amerivantage Classic (HMO) and Amerivantage Select (HMO)** covers and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **http://www.medicare.gov**.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **http://www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About **Amerivantage Classic (HMO) and Amerivantage Select (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-866-805-4589** (TTY **711**).

Este documento está disponible en otros formatos como Braille o textos con letras grandes.

Este documento podría estar disponible en otros idiomas además del inglés. Para información adicional, llame a nosotros al **1-866-805-4589** (TTY **711**).

Tài liệu này có sẵn ở các định dạng khác như chữ nổi Braille và bản in lớn.

Tài liệu này có thể có sẵn bằng ngôn ngữ không phải tiếng Anh. Để biết thêm thông tin, hãy gọi cho chúng tôi theo số **1-866-805-4589** (TTY **711**).

Things to Know About Amerivantage Classic (HMO) and Amerivantage Select (HMO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

Amerivantage Classic (HMO) and Amerivantage Select (HMO) Phone Numbers and Website

- If you are a member of these plans, call toll-free **1-866-805-4589** (TTY **711**).
- If you are not a member of these plans, call toll-free **1-877-470-4131** (TTY **711**).
- Our website: **http://www.myamerigroup.com/medicare.**

Who can join?

To join **Amerivantage Classic (HMO) and Amerivantage Select (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following county in Texas: Harris.

Which doctors, hospitals, and pharmacies can I use?

Amerivantage Classic (HMO) and Amerivantage Select (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider and pharmacy directory at our website (**http://www.myamerigroup.com/medicare**).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **http://www.myamerigroup.com/medicare**.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plans group each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits

January 1, 2016 - December 31, 2016

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services		
How much is the monthly premium?	**$0** per month. In addition, you must keep paying your Medicare Part B premium.	**$0** per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • **$6,700** for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • **$4,500** for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

AMERIGROUP Texas, Inc. is an HMO plan with a Medicare contract. Enrollment in AMERIGROUP Texas, Inc. depends on contract renewal.

Covered Medical and Hospital Benefits		
Note: • Services with a [1] may require prior authorization. • Services with a [2] may require a referral from your doctor.		
Outpatient Care and Services		
Acupuncture	Not covered	Not covered
Ambulance[1]	**$275** copay or **20%** of the cost, depending on the service **20%** coinsurance applies for each Medicare-covered air ambulance trip. The copay applies for all other Medicare-covered ambulance trips.	**$210** copay
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **$20** copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **$20** copay
Dental Services	Limited dental services (this does not include services in connection with care, treatment,	Limited dental services (this does not include services in connection with care, treatment,

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Dental Services (continued)	filling, removal, or replacement of teeth): **$30** copay Preventive dental services: • Cleaning (for up to 2 every year): **You pay nothing** • Dental x-ray(s) (for up to 1 every year): **You pay nothing** • Oral exam (for up to 2 every year): **You pay nothing**	filling, removal, or replacement of teeth): **$25** copay Preventive dental services: • Cleaning (for up to 2 every year): **You pay nothing** • Dental x-ray(s) (for up to 1 every year): **You pay nothing** • Oral exam (for up to 2 every year): **You pay nothing**
Diabetes Supplies and Services[1,2]	Diabetes monitoring supplies: **You pay nothing** Diabetes self-management training: **20%** of the cost Therapeutic shoes or inserts: **You pay nothing**	Diabetes monitoring supplies: **You pay nothing** Diabetes self-management training: **20%** of the cost Therapeutic shoes or inserts: **You pay nothing**
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): **$50-60** copay, depending on the service Diagnostic tests and procedures: **$0-60** copay, depending on the service Lab services: **You pay nothing** Outpatient x-rays: **$35-60** copay, depending on the service Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost	Diagnostic radiology services (such as MRIs, CT scans): **$50-60** copay, depending on the service Diagnostic tests and procedures: **$0-60** copay, depending on the service Lab services: **You pay nothing** Outpatient x-rays: **$10-20** copay, depending on the service Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Doctor's Office Visits[1,2]	Primary care physician visit: **$5** copay Specialist visit: **$30** copay	Primary care physician visit: **You pay nothing** Specialist visit: **$25** copay
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	**20%** of the cost	**20%** of the cost
Emergency Care	**$75** copay This plan offers limited coverage for urgent and emergency care outside of the United States. This plan may provide coverage up to a **$25,000** limit.	**$75** copay This plan offers limited coverage for urgent and emergency care outside of the United States. This plan may provide coverage up to a **$25,000** limit.
Foot Care *(podiatry services)*[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$30** copay Routine foot care (for up to 4 visit(s) every year): **$30** copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$25** copay Routine foot care (for up to 4 visit(s) every year): **$25** copay
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: **$30** copay Routine hearing exam (for up to 1 every year): **$0** copay Hearing aid fitting/evaluation (for up to 1 every year): **$0** copay Hearing aid: **$0** copay	Exam to diagnose and treat hearing and balance issues: **$25** copay Routine hearing exam (for up to 1 every year): **$0** copay Hearing aid fitting/evaluation (for up to 1 every year): **$0** copay Hearing aid: **$0** copay

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Hearing Services[1,2] (continued)	Our plan pays up to **$1,000** every year for hearing aids.	Our plan pays up to **$1,000** every year for hearing aids.
Home Health Care[1,2]	**You pay nothing**	**You pay nothing**
Mental Health Care[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Mental Health Care[1,2] (continued)	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • **$215** copay per day for days 1 through 7 • **You pay nothing** per day for days 8 through 90 Outpatient group therapy visit: **$30** copay Outpatient individual therapy visit: **$30** copay In-network per day cost-sharing applies to each inpatient admission within a benefit period (note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost-sharing per day applies).	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • **$150** copay per day for days 1 through 6 • **You pay nothing** per day for days 7 through 90 Outpatient group therapy visit: **$25** copay Outpatient individual therapy visit: **$25** copay In-network per day cost-sharing applies to each inpatient admission within a benefit period (note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost-sharing per day applies).
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **$30** copay Occupational therapy visit: **$30** copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **$25** copay Occupational therapy visit: **$25** copay

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Outpatient Rehabilitation[1,2] (continued)	Physical therapy and speech and language therapy visit: **$30** copay	Physical therapy and speech and language therapy visit: **$25** copay
Outpatient Substance Abuse[1,2]	Group therapy visit: **$30** copay Individual therapy visit: **$30** copay	Group therapy visit: **$25** copay Individual therapy visit: **$25** copay
Outpatient Surgery[1,2]	Ambulatory surgical center: **$0-150** copay, depending on the service Outpatient hospital: **$0-250** copay, depending on the service	Ambulatory surgical center: **$0-150** copay, depending on the service Outpatient hospital: **$0-150** copay, depending on the service
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. You pay nothing for over-the-counter items up to **$20** per quarter for plan-approved health care items like over-the-counter medications. Unused allowances do roll over to the next quarter. Unused allowances do not roll over to the next calendar year. Orders are limited to one per month.	Please visit our website to see our list of covered over-the-counter items. You pay nothing for over-the-counter items up to **$20** per quarter for plan-approved health care items like over-the-counter medications. Unused allowances do roll over to the next quarter. Unused allowances do not roll over to the next calendar year. Orders are limited to one per month.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: **20%** of the cost Related medical supplies: **20%** of the cost	Prosthetic devices: **20%** of the cost Related medical supplies: **20%** of the cost

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Renal Dialysis	**20%** of the cost	**20%** of the cost
Transportation[1]	**You pay nothing** Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by the contracted transportation vendor. Members are covered for up to **20** one-way health-related trips per year. 48 hours advanced notice is required when scheduling.	**You pay nothing** Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by the contracted transportation vendor. Members are covered for up to **20** one-way health-related trips per year. 48 hours advanced notice is required when scheduling.
Urgently Needed Services	**$35** copay **$75** copay for limited coverage of urgent and emergency care outside of the United States. This plan may provide coverage up to a **$25,000** limit.	**$10** copay **$75** copay for limited coverage of urgent and emergency care outside of the United States. This plan may provide coverage up to a **$25,000** limit.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$0-30** copay, depending on the service Routine eye exam (for up to 1 every year): **$0** copay Contact lenses: **$0** copay Eyeglasses (frames and lenses): **$0** copay Eyeglass frames: **$0** copay Eyeglass lenses: **$0** copay	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$0-25** copay, depending on the service Routine eye exam (for up to 1 every year): **$0** copay Contact lenses: **$0** copay Eyeglasses (frames and lenses): **$0** copay Eyeglass frames: **$0** copay Eyeglass lenses: **$0** copay

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Vision Services (continued)	Eyeglasses or contact lenses after cataract surgery: **20%** of the cost Our plan pays up to **$100** every year for eyewear.	Eyeglasses or contact lenses after cataract surgery: **20%** of the cost Our plan pays up to **$100** every year for eyewear.
Preventive Care[1]	**You pay nothing** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA)	**You pay nothing** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA)

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Preventive Care[1] (continued)	• Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Annual physical exam: **You pay nothing**	• Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Annual physical exam: **You pay nothing**
Hospice	**You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	**You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Inpatient Care		
Inpatient Hospital Care[1]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Inpatient Hospital Care[1] (continued)	inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • **$250** copay per day for days 1 through 7 • **You pay nothing** per day for days 8 through 90 In-network per day cost-sharing applies to each inpatient admission within a benefit period (note: transfers to an inpatient rehabilitation hospital is	inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • **$150** copay per day for days 1 through 6 • **You pay nothing** per day for days 7 through 90 In-network per day cost-sharing applies to each inpatient admission within a benefit period (note: transfers to an inpatient rehabilitation hospital is

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Inpatient Hospital Care[1] (continued)	considered a new admission and cost-sharing per day applies).	considered a new admission and cost-sharing per day applies).
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • **You pay nothing** per day for days 1 through 20 • **$150** copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. • **You pay nothing** per day for days 1 through 20 • **$150** copay per day for days 21 through 100
Prescription Drug Benefits		
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: **20%** of the cost Other Part B drugs[1]: **20%** of the cost	For Part B drugs such as chemotherapy drugs[1]: **20%** of the cost Other Part B drugs[1]: **20%** of the cost
Initial Coverage	You pay the following until your total yearly drug costs reach **$3,150.** Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach **$3,050.** Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Initial Coverage (continued)		**Amerivantage Classic (HMO)**	**Amerivantage Select (HMO)**
	Standard Retail Cost-Sharing		
	Tier 1 (Preferred Generic)		
	One-month supply	**$9** copay	**$7** copay
	Two-month supply	**$18** copay	**$14** copay
	Three-month supply	**$27** copay	**$21** copay
	Tier 2 (Generic)		
	One-month supply	**$17** copay	**$13** copay
	Two-month supply	**$34** copay	**$26** copay
	Three-month supply	**$51** copay	**$39** copay
	Tier 3 (Preferred Brand)		
	One-month supply	**$47** copay	**$47** copay
	Two-month supply	**$94** copay	**$94** copay
	Three-month supply	**$141** copay	**$141** copay
	Tier 4 (Non-Preferred Brand)		
	One-month supply	**$100** copay	**$100** copay
	Two-month supply	**$200** copay	**$200** copay
	Three-month supply	**$300** copay	**$300** copay
	Tier 5 (Specialty Tier)		
	One-month supply	**33%** of the cost	**33%** of the cost
	Two-month supply	Not Offered	Not Offered
	Three-month supply	Not Offered	Not Offered
	Tier 6 (Select Care Drugs)		
	One-month supply	**$0**	**$0**
	Two-month supply	**$0**	**$0**
	Three-month supply	**$0**	**$0**

Initial Coverage (continued)		**Amerivantage Classic (HMO)**	**Amerivantage Select (HMO)**
	Preferred Retail Cost-Sharing		
	Tier 1 (Preferred Generic)		
	One-month supply	**$4** copay	**$2** copay
	Two-month supply	**$8** copay	**$4** copay
	Three-month supply	**$12** copay	**$6** copay
	Tier 2 (Generic)		
	One-month supply	**$12** copay	**$8** copay
	Two-month supply	**$24** copay	**$16** copay
	Three-month supply	**$36** copay	**$24** copay
	Tier 3 (Preferred Brand)		
	One-month supply	**$42** copay	**$42** copay
	Two-month supply	**$84** copay	**$84** copay
	Three-month supply	**$126** copay	**$126** copay
	Tier 4 (Non-Preferred Brand)		
	One-month supply	**$95** copay	**$95** copay
	Two-month supply	**$190** copay	**$190** copay
	Three-month supply	**$285** copay	**$285** copay
	Tier 5 (Specialty Tier)		
	One-month supply	**33%** of the cost	**33%** of the cost
	Two-month supply	Not Offered	Not Offered
	Three-month supply	Not Offered	Not Offered
	Tier 6 (Select Care Drugs)		
	One-month supply	**$0**	**$0**
	Two-month supply	**$0**	**$0**
	Three-month supply	**$0**	**$0**

Initial Coverage (continued)		**Amerivantage Classic (HMO)**	**Amerivantage Select (HMO)**
	Standard Mail Order Cost-Sharing		
	Tier 1 (Preferred Generic)		
	One-month supply	**$4** copay	**$2** copay
	Two-month supply	**$12** copay	**$6** copay
	Three-month supply	**$12** copay	**$6** copay
	Tier 2 (Generic)		
	One-month supply	**$12** copay	**$8** copay
	Two-month supply	**$36** copay	**$24** copay
	Three-month supply	**$36** copay	**$24** copay
	Tier 3 (Preferred Brand)		
	One-month supply	**$42** copay	**$42** copay
	Two-month supply	**$126** copay	**$126** copay
	Three-month supply	**$126** copay	**$126** copay
	Tier 4 (Non-Preferred Brand)		
	One-month supply	**$95** copay	**$95** copay
	Two-month supply	**$285** copay	**$285** copay
	Three-month supply	**$285** copay	**$285** copay
	Tier 5 (Specialty Tier)		
	One-month supply	**33%** of the cost	**33%** of the cost
	Two-month supply	Not Offered	Not Offered
	Three-month supply	Not Offered	Not Offered
	Tier 6 (Select Care Drugs)		
	One-month supply	**$0**	**$0**
	Two-month supply	**$0**	**$0**
	Three-month supply	**$0**	**$0**

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Initial Coverage (continued)	If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,150.** After you enter the coverage gap, you pay **45%** of the plan's cost for covered brand name drugs and **58%** of the plan's cost for covered generic drugs until your costs total **$4,850,** which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,050.** After you enter the coverage gap, you pay **45%** of the plan's cost for covered brand name drugs and **58%** of the plan's cost for covered generic drugs until your costs total **$4,850,** which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Coverage Gap (continued)	find out how much it will cost you.	find out how much it will cost you.

Coverage Gap (continued)		**Amerivantage Classic (HMO)**	**Amerivantage Select (HMO)**
	Standard Retail Cost-Sharing		
	Tier 6 (Select Care Drugs)		
	Drugs Covered	All	All
	One-month supply	**$0**	**$0**
	Two-month supply	**$0**	**$0**
	Three-month supply	**$0**	**$0**
	Preferred Retail Cost-Sharing		
	Tier 6 (Select Care Drugs)		
	Drugs Covered	All	All
	One-month supply	**$0**	**$0**
	Two-month supply	**$0**	**$0**
	Three-month supply	**$0**	**$0**
	Standard Mail Order Cost-Sharing		
	Tier 6 (Select Care Drugs)		
	Drugs Covered	All	All
	One-month supply	**$0**	**$0**
	Two-month supply	**$0**	**$0**
	Three-month supply	**$0**	**$0**

	Amerivantage Classic (HMO)	Amerivantage Select (HMO)
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,850,** you pay the greater of: • **5%** of the cost, or • **$2.95** copay for generic (including brand drugs treated as generic) and a **$7.40** copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,850,** you pay the greater of: • **5%** of the cost, or • **$2.95** copay for generic (including brand drugs treated as generic) and a **$7.40** copayment for all other drugs.

Additional Information

Amerigroup: We're here to help.
Amerigroup is more than a company that provides medical coverage. We're a group of people committed to your health. Now, when times are tougher for many of us, Amerigroup is committed to helping everyone get the tools and solutions they need to lead healthier lives.

Looking for Medicare coverage that goes beyond Original Medicare?
Amerigroup works with the federal government to bring you even more benefits than you get with Original Medicare. Lower copays, extra benefits, pharmacy and medical coverage, advice from nurses and many other important health benefits are yours from one company — all **with $0 monthly plan premiums**.

Our plan gives you extra benefits not included in Original Medicare, such as:

Personal Emergency Response System (PERS)	Coverage of personal emergency response service and monitoring system arranged by the plan.
Annual Physical Exams	An annual routine physical exam (beyond your initial preventive physical exam or annual wellness visit).
Telemonitoring	Coverage of in-home equipment and telecommunication technology to monitor specific health conditions.
Silver Sneakers	Access to the SilverSneakers® fitness classes, including home-based and facility-based programs and use of all contracted network fitness centers.

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 1-866-805-4589. 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 1-866-805-4589. 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 1-866-805-4589。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1-866-805-4589。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 1-866-805-4589. 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 1-866-805-4589. 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 1-866-805-4589 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 1-866-805-4589. 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 1-866-805-4589 번으로 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 1-866-805-4589. 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 1-668-508-9854. سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

Hindi: हमारे सवासथय या दवा की योजना के बारे में आपके किसी भी पशन के जवाब देने के लिए हमारे पास मुफत दुभाषिया सेवाएँ उपलबध हैं. एक दुभायिषा परापत करने के लिए, बस हमें 1-866-805-4589 पर फोन करें. कोई वयकित जो हिनदी बोलता है आपकी मदद कर सकता है. यह एक मुफत सेवा है.

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 1-866-805-4589. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-805-4589. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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 1-866-805-4589. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-805-4589. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-805-4589 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Amerigroup - H5817

2016 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.

2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2016, Amerigroup received the following Overall Star Rating from Medicare.

4 Stars

We received the following Summary Star Rating for Amerigroup 's health/drug plan services:

Health Plan Services:	 3.5 Stars
Drug Plan Services:	 4 Stars

The number of stars shows how well our plan performs.

	5 stars - excellent
	4 stars - above average
	3 stars - average
	2 stars - below average
	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 11:00 p.m. Eastern time at 844-316-0355 (toll-free) or 711 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 11:00 p.m. Eastern time.

Current members please call 866-805-4589 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.