Amerigroup RealSolutions®
Medicare Advantage Plans

Summary of Benefits

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

Available in: Fort Bend, Harris, and Montgomery Counties

Plan year: January 1, 2017 – December 31, 2017

In this section, you'll learn about some of the services we cover, what you'll pay for those services and other important details to help you choose the right Medicare Advantage plan for you. While the benefit information provided does not list every service that we cover or list every limitation or exclusion, you can get a complete list of those services. Just give us a call and ask for the *Evidence of Coverage.*

Have questions? Here's how to reach us and our hours of operation:

- If you **are not** a member of this plan, please call toll free **1-877-470-4131** (TTY: **711**), and follow the instructions to be connected to a representative.
- If you **are** a member of this plan, call our toll-free Customer Service number at **1-866-805-4589** (TTY: **711**).
- **8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.**
- You can learn more about us on our website at **www.myamerigroup.com/medicare**.

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What you should know about our plans

Amerivantage Select (HMO) and **Amerivantage Classic (HMO)** are Medicare Advantage and prescription drug plans, which includes hospital, medical and prescription drug benefits in one plan. To join these plans, you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Our service area includes: TX: Fort Bend, Harris, Montgomery

With these plans, you must use a provider in the plan's network. If you use providers that are not in our network, the plan may not pay for these services.

You can find a doctor in the network online — visit **www.myamerigroup.com/medicare** and choose Find a Doctor. *(Be sure to check that the doctor displays as "In-Network" for these plans.)* Or you can call Customer Service and request a copy of the provider directory.

What do we cover?

- Like all Medicare health plans, we cover everything that Original Medicare covers — Part A (hospital services) and Part B (medical services), plus more. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less (see benefits section for more details).
- Medicare Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider).
- To see if your drugs are covered, you can view the plan's *Formulary* (list of covered Part D prescription drugs) and any restrictions on our website at **www.myamerigroup.com/medicare**. Or you can call us for a copy of the *Formulary*.

What are my drug costs?

Our plan groups each medication into one of six "tiers." The amount you pay depends on the drug's tier and what stage of the benefit you have reached (refer to **The four stages of coverage**).

How to find out what your covered drugs will cost:

Step 1: Find your drug on the *Formulary*.

Step 2: Next, identify the drug tier.

Step 3: Then, go to the Prescription Drug Benefits section further in this booklet to match the tier.

Can I use any pharmacy to fill my covered prescriptions?

To receive the lowest out-of-pocket costs on your covered Part D drugs, you must generally use a pharmacy in our network. If you use a pharmacy that is not in our network, you may pay more for your covered drugs.

You may be able to save even more money at pharmacies with preferred cost sharing

We've worked with certain network pharmacies to further reduce prices, so you can save more on your covered drugs. Having available preferred pharmacies does not mean you can't use other pharmacies in our network *(pharmacies with standard cost sharing)*, but you may pay more at a pharmacy with standard cost-sharing. Pharmacies with preferred cost-sharing have lower copays and coinsurance amounts for non-specialty drugs than pharmacies with standard cost-sharing.

For a complete listing of network pharmacies, refer to our plan's *Pharmacy Directory* on our website **www.myamerigroup.com/medicare** (under *Useful Tools*, select **Find a Pharmacy**). Next to the pharmacy name, you will see a preferred cost-sharing indicator (a ♦ symbol). Or you can give us a call, and we will send you a copy.

How can I learn more about Medicare or compare my choices with other plans?

- Refer to your current *Medicare & You* handbook. You can view it online at www.medicare.gov or call Medicare for a copy at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or you can go online to www.medicare.gov and use the Medicare Plan Finder.

Now that you are familiar with how Medicare works and some of the benefits included in our plans, it's time to consider the type of plan you may need. On the following pages, you can review our available plans with varying coverage levels to help you choose the right plan for you.

Be in the know

Before you continue, here are a few important things to know as you review our available plan options:

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
How much is my premium?	
$0.00 per month	**$0.00** per month

You must continue to pay your Medicare Part B premium.

How much is my deductible?	
This plan does not have a medical deductible.	This plan does not have a medical deductible.

Is there a limit on how much I will pay for my covered medical services? *(does not include Part D drugs)*	
$2,750 per year from in-network providers	**$4,500** per year from in-network providers

Like all Medicare health plans, our plans protect you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your limit for services received from in-network providers will count toward the yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for the rest of the year for covered in-network Part A and Part B services.

You will still need to pay your monthly premiums (if you have one) and cost sharing for your Part D prescription drugs.

Inpatient Hospital[1]	
In-network: • **$150.00 per stay**	**In-network:** • **Days 1 - 6: $150 per day, per admission / Days 7 - 90: $0 per day, per admission**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Inpatient Hospital[1] - continued	

Both plans cover unlimited inpatient days.

In-network per day cost-sharing applies to each inpatient admission. (note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost-sharing per day applies).

Doctor's Office Visits[1,2]	
Primary care physician visit:	
In-network: $0.00 copay	**In-network: $5.00 copay**
Specialist visit:	
In-network: $25.00 copay	**In-network: $30.00 copay**

Preventive Care Screenings and Annual Physical Exams	
Preventive care screenings:	
In-network: $0.00 copay	**In-network: $0.00 copay**
Annual physical exam:	
In-network: $0.00 copay	**In-network: $0.00 copay**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Preventive Care Screenings and Annual Physical Exams - continued	
Covered Preventive care screenings:	

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual "Wellness" visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings and monitoring
- HIV screening
- Lung cancer screenings
- Medical nutrition therapy services
- Obesity screenings and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings 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)

Any additional preventive services approved by Medicare during the contract year will be covered. These plans cover preventive care screenings and annual physical exams at 100% when you use in-network providers.

Emergency Care	
$75.00 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. If the cost of the service exceeds $25,000, you are responsible for the difference.	**$75.00 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. If the cost of the service exceeds $25,000, you are responsible for the difference.

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Urgently Needed Services	
$25.00 copay	**$30.00 copay**

Diagnostic Radiology Services (such as MRIs, CT scans)[1,2]	
In-Network: $50.00 - $60.00 copay	**In-Network: $50.00 - $60.00 copay**

Costs for these services may vary based on place of service.

Diagnostic Tests and Procedures[1,2]	
In-Network: $0.00 - $60.00 copay	**In-Network: $0.00 - $60.00 copay**

Costs for these services may vary based on place of service.

Lab Services[1,2]	
In-Network: $0.00 copay	**In-Network: $0.00 copay**

Outpatient X-rays[1,2]	
In-Network: $10.00 - $20.00 copay	**In-Network: $35.00 - $60.00 copay**

Costs for these services may vary based on place of service.

Therapeutic Radiology Services (such as radiation treatment for cancer)[1,2]	
In-Network: 20% coinsurance	**In-Network: 20% coinsurance**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Hearing Services[1,2]	
Medicare covered hearing services (Exam to diagnose and treat hearing and balance issues):	
In-network: $25.00 copay	**In-network: $30.00 copay**
Routine hearing services:	
This plan covers 1 routine hearing exam(s) and hearing aid fitting / evaluation(s) every year. $3,000.00 maximum plan benefit for hearing aids every year. **In-network: $0.00 copay for routine hearing exam(s). $0.00 copay for hearing aids.**	**This plan covers 1 routine hearing exam(s) and hearing aid fitting / evaluation(s) every year. $3,000.00 maximum plan benefit for hearing aids every year.** **In-network: $0.00 copay for routine hearing exam(s). $0.00 copay for hearing aids.**
Dental Services	
Medicare covered dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth):	
In-network: $25.00 copay	**In-network: $30.00 copay**
Preventive dental services:	
This plan covers: 2 oral exam(s) every year, 2 cleaning(s) every year, 1 dental x-ray(s) every year. **In-network: $0.00 copay**	**This plan covers: 2 oral exam(s) every year, 2 cleaning(s) every year, 1 dental x-ray(s) every year.** **In-network: $0.00 copay**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Dental Services - continued	
Comprehensive dental services:	
This plan covers up to a $250.00 allowance for comprehensive dental services every quarter. **In-network: $0.00 copay**	Not Covered

Vision Services	
Medicare covered vision services:	
Exam to diagnose and treat diseases and conditions of the eye	
In-network: $0.00 - $25.00 copay	**In-network: $0.00 - $30.00 copay**

Eyeglasses or contact lenses after cataract surgery	
In-network: 20% coinsurance	**In-network: 20% coinsurance**

Routine vision services:	
Routine eye exam	
This plan covers 1 routine eye exam(s) every year. **In-network: $0.00 copay**	**This plan covers 1 routine eye exam(s) every year.** **In-network: $0.00 copay**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Vision Services - continued	
Routine eye wear	
This plan covers up to $100.00 for eye glasses or contact lenses every year. **In-network: $0.00 copay**	**This plan covers up to $100.00 for eye glasses or contact lenses every year.** **In-network: $0.00 copay**

Mental Health Care	
Inpatient visit:[1]	
In-network: $150.00 per stay	**In-network: Days 1-6: $150 per day, per admission / Days 7-90: $0 per day, per admission**

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.

Both plans cover unlimited inpatient days.

In-network per day cost-sharing applies to each inpatient admission. (note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost-sharing per day applies).

Outpatient individual and group therapy visit:[1,2]	
In-network: $25.00 copay	**In-network: $30.00 copay**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Skilled Nursing Facility (SNF)[1]	
In-network: Days 1 - 20: $0 per day / Days 21 - 100: $150 per day	**In-network: Days 1 - 20: $0 per day / Days 21 - 100: $150 per day**

These plans cover up to 100 days in a Skilled Nursing Facility (SNF).

The copays for SNF benefits are based on benefit periods. A benefit period begins the day you're admitted to the hospital or skilled nursing facility and ends when you haven't received any inpatient hospital care or skilled nursing care for 60 days in a row. If you are admitted to an SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

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):	
In-network: $25.00 copay	**In-network: $30.00 copay**
Pulmonary (lung) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions):	
In-network: $25.00 copay	**In-network: $30.00 copay**
Occupational therapy visit:	
In-network: $25.00 copay	**In-network: $30.00 copay**
Physical therapy and speech/language therapy visit:	
In-network: $25.00 copay	**In-network: $30.00 copay**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Ambulance[1]	
Ground/Water Ambulance: **In-network: $210.00 copay** per trip **Air Ambulance:** **In-network: $210.00 copay** per trip	**Ground/Water Ambulance:** **In-network: $275.00 copay** per trip **Air Ambulance:** **In-network: 20% coinsurance** per trip

Transportation[1]	
In-Network: $0.00 copay **This plan offers coverage for 20 one way routine transportation services every year. Trips are limited to 60 miles.**	**In-Network: $0.00 copay** **This plan offers coverage for 20 one way routine transportation services every year. Trips are limited to 60 miles.**

Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by the contracted transportation vendor. 48 hours advanced notice is required when scheduling.

Foot Care *(podiatry services)*[1,2]	
Medicare covered podiatry:	
In-network: $25.00 copay	**In-network: $30.00 copay**

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.

Routine foot care:	
In-network: $0.00 copay This plan covers 24 routine foot care visit(s) every year.	**In-network: $0.00 copay** This plan covers 24 routine foot care visit(s) every year.

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Medical Equipment/Supplies[1]	
Durable Medical Equipment (wheelchairs, oxygen, etc.)	
In-network: 20% coinsurance	**In-network: 20% coinsurance**
Medical supplies and prosthetic devices (braces, artificial limbs, etc.)	
In-network: 20% coinsurance	**In-network: 20% coinsurance**
Diabetic supplies and services	
In-network: $0.00 copay	**In-network: $0.00 copay**
Wellness Programs	
Healthways SilverSneakers®* Fitness program: You pay nothing	**Healthways SilverSneakers®* Fitness program:** You pay nothing

When you become our member, you can sign up for SilverSneakers. Additional details can be found at **www.silversneakers.com**. Or you can call SilverSneakers Customer Service at **1-855-741- 4985** (TTY: **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

* The SilverSneakers Fitness Program is provided by Healthways, Inc., an independent company. Healthways and SilverSneakers® are registered marks of Healthways, Inc. and/or its subsidiaries.

Medicare Part B Drugs[1]	
In-network: 20% coinsurance	**In-network: 20% coinsurance**

The four stages of drug coverage

What you pay for your covered drugs depends, in part, on which coverage stage you are in.




Stage 1	Stage 2	Stage 3	Stage 4
Deductible	**Initial Coverage**	**Coverage Gap**	**Catastrophic Coverage**
If you have a deductible, you will pay **100%** of your drug cost until your deductible is met. (If you have no deductible, or if a specific drug tier does not apply to the deductible, you will skip to Stage 2.)	You will pay a copay or coinsurance, and your plan pays the rest for your covered drugs	In this stage, you pay a greater share of the costs. It begins after you and your plan have paid a certain amount, which can vary by plan, on covered drugs during Stages 1 and 2. See Stage 2: Initial Coverage below for the exact amount. After you enter the coverage gap, you pay **40%** of the plan's cost for covered brand-name drugs and **51%** of the plan's cost for covered generic drugs until your costs total **$4,950**. Some plans have additional coverage. See the Coverage Gap section on later pages for details.	In this stage, after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay the greater of: • **5%** of the cost, or • **$3.30** copay for generic (including brand drugs treated as generic) and a **$8.25** copayment for all other drugs.

Which coverage stage am I in?

You will get an *Explanation of Benefits* (EOB) each month you fill a prescription. It will show which coverage stage you're in and how close you are to entering the next one.

Outpatient Prescription Drug Benefits

How much do I pay for Part D drugs?

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Stage 1: Deductible	
This plan does not have a deductible	This plan does not have a deductible
Stage 2: Initial Coverage	
After you pay your yearly deductible (if your plan has one), you pay the following until your total yearly drug costs reach **$3,700**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	After you pay your yearly deductible (if your plan has one), you pay the following until your total yearly drug costs reach **$3,700**. 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 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.

Stage 2: Initial Coverage - Preferred Retail Cost Sharing	
Tier 1: Preferred Generic	
One-month supply: **$2.00** copay Three-month supply: **$6.00** copay	One-month supply: **$4.00** copay Three-month supply: **$12.00** copay

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Stage 2: Initial Coverage - Preferred Retail Cost Sharing - continued	
Tier 2: Generic	
One-month supply: **$4.00** copay Three-month supply: **$12.00** copay	One-month supply: **$9.00** copay Three-month supply: **$27.00** copay
Tier 3: Preferred Brand	
One-month supply: **$42.00** copay Three-month supply: **$126.00** copay	One-month supply: **$42.00** copay Three-month supply: **$126.00** copay
Tier 4: Nonpreferred Drugs	
One-month supply: **$95.00** copay Three-month supply: **$285.00** copay	One-month supply: **$95.00** copay Three-month supply: **$285.00** copay
Tier 5: Specialty Tier	
One-month supply: **33%** of the cost Three-month supply: **N/A**	One-month supply: **33%** of the cost Three-month supply: **N/A**
Tier 6: Select Care Drugs	
One-month supply: **$0.00** copay Three-month supply: **$0.00** copay	One-month supply: **$0.00** copay Three-month supply: **$0.00** copay

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Stage 2: Initial Coverage - Standard Retail Cost Sharing	
Tier 1: Preferred Generic	
One-month supply: **$7.00** copay Three-month supply: **$21.00** copay	One-month supply: **$9.00** copay Three-month supply: **$27.00** copay
Tier 2: Generic	
One-month supply: **$9.00** copay Three-month supply: **$27.00** copay	One-month supply: **$14.00** copay Three-month supply: **$42.00** copay
Tier 3: Preferred Brand	
One-month supply: **$47.00** copay Three-month supply: **$141.00** copay	One-month supply: **$47.00** copay Three-month supply: **$141.00** copay
Tier 4: Nonpreferred Drugs	
One-month supply: **$100.00** copay Three-month supply: **$300.00** copay	One-month supply: **$100.00** copay Three-month supply: **$300.00** copay
Tier 5: Specialty Tier	
One-month supply: **33%** of the cost Three-month supply: **N/A**	One-month supply: **33%** of the cost Three-month supply: **N/A**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Stage 2: Initial Coverage - Standard Retail Cost Sharing - continued	
Tier 6: Select Care Drugs	
One-month supply: **$0.00** copay Three-month supply: **$0.00** copay	One-month supply: **$0.00** copay Three-month supply: **$0.00** copay
Stage 2: Initial Coverage - Standard Mail Order Cost Sharing	
Tier 1: Preferred Generic	
One-month supply: **$2.00** copay Three-month supply: **$6.00**	One-month supply: **$4.00** copay Three-month supply: **$12.00** copay
Tier 2: Generic	
One-month supply: **$4.00** copay Three-month supply: **$12.00** copay	One-month supply: **$9.00** copay Three-month supply: **$27.00** copay
Tier 3: Preferred Brand	
One-month supply: **$42.00** copay Three-month supply: **$126.00** copay	One-month supply: **$42.00** copay Three-month supply: **$126.00** copay

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Stage 2: Initial Coverage - Standard Mail Order Cost Sharing - continued	
Tier 4: Nonpreferred Drugs	
One-month supply: **$95.00** copay Three-month supply: **$285.00** copay	One-month supply: **$95.00** copay Three-month supply: **$285.00** copay
Tier 5: Specialty Tier	
One-month supply: **33%** of the cost Three-month supply: **N/A**	One-month supply: **33%** of the cost Three-month supply: **N/A**
Tier 6: Select Care Drugs	
One-month supply: **$0.00** copay Three-month supply: **$0.00** copay	One-month supply: **$0.00** copay Three-month supply: **$0.00** copay

Stage 3: Coverage Gap

After you enter the coverage gap, you pay **40%** of the plan's cost for covered brand name drugs and **51%** of the plan's cost for covered generic drugs until your costs total **$4,950**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

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. For additional gap coverage, see the chart that follows to find out how much your drugs will cost you.

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Stage 3: Coverage Gap - Preferred Retail Cost Sharing	
Tier 6: Select Care Drugs	
Drugs Covered: **All** One-month supply: **$0.00** copay Three-month supply: **$0.00** copay	Drugs Covered: **All** One-month supply: **$0.00** copay Three-month supply: **$0.00** copay
Stage 3: Coverage Gap - Standard Retail Cost Sharing	
Tier 6: Select Care Drugs	
Drugs Covered: **All** One-month supply: **$0.00** copay Three-month supply: **$0.00** copay	Drugs Covered: **All** One-month supply: **$0.00** copay Three-month supply: **$0.00** copay
Stage 3: Coverage Gap - Standard Mail Order Cost-Sharing	
Tier 6: Select Care Drugs	
Drugs Covered: **All** One-month supply: **$0.00** copay Three-month supply: **$0.00** copay	Drugs Covered: **All** One-month supply: **$0.00** copay Three-month supply: **$0.00** copay

Amerivantage Select (HMO)	Amerivantage Classic (HMO)

Stage 4: Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay the greater of:

- **5%** of the cost, or
- **$3.30** copay for generic (including brand drugs treated as generic) and a **$8.25** copayment for all other drugs.

Additional Benefits

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Chiropractic Care[1,2]	
In-Network: $20.00 copay	**In-Network: $20.00 copay**

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

Home Health Care[1,2]	
In-Network: $0.00 copay	**In-Network: $0.00 copay**

Outpatient Substance Abuse[1,2]	
Individual & Group therapy visit:	
In-Network: $25.00 copay	**In-Network: $30.00 copay**

Outpatient Surgery[1,2]	
Ambulatory surgical center:	
In-Network: $25.00 copay	**In-Network: $100.00 copay**

Outpatient hospital:	
In-Network: $50.00 copay	**In-Network: $150.00 copay**

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Over-the-Counter Items	
This plan covers certain approved non-prescription over-the-counter drugs and health related items; up to $20 every quarter. Unused OTC amounts do roll over to the next quarter. Unused OTC amounts 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.	**This plan covers certain approved non-prescription over-the-counter drugs and health related items; up to $20 every quarter. Unused OTC amounts do roll over to the next quarter. Unused OTC amounts 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.
Renal Dialysis	
In-Network: 20% coinsurance	**In-Network: 20% coinsurance**

More ways we support your health

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:

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Personal Emergency Response System (PERS): Coverage of a Personal Emergency Response System (PERS) which includes the monitoring device and monitoring service. Members should contact customer service to initiate this service and installation. Please refer to the Evidence of Coverage for additional information.	**Personal Emergency Response System (PERS):** Coverage of a Personal Emergency Response System (PERS) which includes the monitoring device and monitoring service. Members should contact customer service to initiate this service and installation. Please refer to the Evidence of Coverage for additional information.
Telemonitoring: Coverage of in-home equipment and telecommunication technology to monitor specific health conditions.	**Telemonitoring:** Coverage of in-home equipment and telecommunication technology to monitor specific health conditions.
24/7 Nurse HelpLine: 24-hour access to a nurse helpline, 7 days a week, 365 days a year.	**24/7 Nurse HelpLine:** 24-hour access to a nurse helpline, 7 days a week, 365 days a year.

Amerivantage Select (HMO)	Amerivantage Classic (HMO)
Healthways SilverSneakers®* Fitness program: You pay nothing	**Healthways SilverSneakers®* Fitness program:** You pay nothing

When you become our member, you can sign up for SilverSneakers. Additional details can be found at **www.silversneakers.com**. Or you can call SilverSneakers Customer Service at **1-855-741-4985** (TTY: **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

* The SilverSneakers Fitness Program is provided by Healthways, Inc., an independent company. Healthways and SilverSneakers® are registered marks of Healthways, Inc. and/or its subsidiaries.

This document is available in other formats such as Braille. This information is available for free in other languages. Please call our Customer Service number at **1-866-805-4589** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week, October 1 to February 14 (except holidays); 8 a.m. to 8 p.m., Monday – Friday, February 15 to September 30 (except holidays).

Este documento está disponible en otros formatos, como braille. Esta información está disponible en otros idiomas de manera gratuita. LLame al servicio de atención al cliente al **1-866-805-4589**(TTY: **711**), de 8 a. m. a 8 p. m., los 7 dias de la semana (excepto los dias feriados) desde el 1° de octubre hasta el 14 de febrero, y de 8 a. m. a 8 p. m., de lunes a viernes (except los dias feriados) del 15 de febrero hasta el 30 de septiembre.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-805-4589 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-805-4589 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-805-4589 (رقم هاتف الصم والبكم: 711).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-866-805-4589 (TTY (հեռատիպ)՝ 711):

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-805-4589（TTY：711）。

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با1-866-805-4589 (TTY: 711)تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-805-4589 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-805-4589 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-805-4589 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-805-4589 (TTY: 711) पर कॉल करें।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-805-4589 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-805-4589 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-805-4589（TTY:711）まで、お電話にてご連絡ください。

Khmer: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-805-4589 (TTY: 711)។

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-805-4589 (TTY: 711) 번으로 전화해 주십시오.

Lao: ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັ ຽຄ່າ, ແມ່ນມີ ພ້ ອມໃຫ້ ທ່ານ. ໂທ 1-866-805-4589 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti’go **Diné Bizaad**, saad bee áká’ánída’áwo’dęę’, t’áá jiik’eh, éí ná hóló, kojį’ hódíílnih 1-866-805-4589 (TTY: 711.)

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-866-805-4589 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-805-4589 (телетайп: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-805-4589 (TTY: 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-805-4589 (TTY: 711).

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .1-866-805-4589 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-805-4589 (TTY: 711).

Amerigroup - H5817

2017 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 2017, Amerigroup received the following Overall Star Rating from Medicare.

3.5 Stars

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

Health Plan Services:	 3.5 Stars
Drug Plan Services:	 3.5 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.

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability in our health programs and activities.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-316-0355 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-316-0355 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-316-0355 (TTY: 711).

Current members please call 1-866-805-4589 (toll-free) or 711 (TTY).

* Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

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

It’s important we treat you fairly
That’s why we follow Federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.