



January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of AmeriHealth Medicare HMO

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). Hours are seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. This call is free.

This plan, AmeriHealth Medicare HMO, is offered by AmeriHealth HMO, INC ("AmeriHealth"). (When this *Evidence of Coverage* says "we," "us," or "our," it means AmeriHealth HMO, INC. When it says "plan" or "our plan," it means AmeriHealth Medicare HMO.)

This document is available for free in Spanish. To receive this document in an alternate format such as braille, data CD, large print, or audio, please contact our Member Help Team.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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OMB Approval 0938-1051 (Expires: July 31, 2029)

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of AmeriHealth Medicare Classic Rx HMO

Section 1.1 You're enrolled in AmeriHealth Medicare Classic Rx HMO, which is a Medicare HMO plan

You're covered by Medicare, and you chose to get your Medicare health and your drug coverage through our plan, AmeriHealth Medicare HMO. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

AmeriHealth Medicare Classic Rx HMO is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how AmeriHealth Medicare HMO covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get 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 you're enrolled in AmeriHealth Medicare HMO between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of AmeriHealth Medicare HMO after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B.

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- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for AmeriHealth Medicare HMO

AmeriHealth Medicare HMO is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes these counties in New Jersey: Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, Ocean.

If you move out of our plan's service area, you can't stay a member of this plan. Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify AmeriHealth Medicare HMO if you're not eligible to stay a member of our plan on this basis. AmeriHealth Medicare HMO must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:

	
PLAN: 80840	
MEMBER ID:	
<ID #>	
<FIRST_NAME>	
RxBIN	610011
RxPCN	CTRXMEDD
RxGRP	MDCMEDNJ
CMS	H5361003
PCP Visit	<>
Specialist Visit	<>
Emergency Room	<>
VISION DENTAL	
	

Visit www.amerhealthmedicare.com for benefit information.

Member: Present this card to providers when seeking care. Before getting services from out-of-network providers you are encouraged to confirm that the services you are getting are covered and are medically necessary. Medicare limiting charges apply.

Please send all written inquiries to: AmeriHealth Medicare HMO
1901 Market Street
Philadelphia, PA 19103

Dental Claims
PO Box 211424
Eagan, MN 55121

Submit prescription claims to Prescription Drug Claims, P.O. Box 650287 Dallas, TX 75265-0287.

Member Help Team
1-866-569-5190
TTY/TDD 711
Mental Health/Substance Abuse 1-800-809-9954
Mail Order Pharmacy 1-888-678-7015

Submit paper medical claims to:
AmeriHealth Medicare HMO
Claims Receipt Center
P.O. Box 211184
Eagan, MN 55121

Benefits underwritten by AmeriHealth Insurance Company of New Jersey, Inc. Vision services administered by Davis Vision an independent company. AmeriHealth Medicare Dental Network administered by Dominion Dental Services, Inc., an independent company.

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your AmeriHealth Medicare HMO 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 our plan membership card is damaged, lost, or stolen, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) right away and we'll send you a new card.

Section 3.2 Provider/Pharmacy Directory

The *Provider/Pharmacy Directory* www.amerhealthmedicare.com/directory lists our current 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'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when AmeriHealth Medicare HMO authorizes use of out-of-network providers.

The *Provider/Pharmacy Directory* (www.amerhealthmedicare.com/directory) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

The *Provider/Pharmacy Directory* also shows which pharmacies in our network have preferred cost sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

The most recent list of providers suppliers and pharmacies is available on our website at www.amerihealthmedicare.com/directory.

If you don't have a *Provider/Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). Requested paper *Provider/Pharmacy Directory* will be mailed to you within 3 business days.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in AmeriHealth Medicare HMO. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 5, Section 6. Medicare approved the AmeriHealth Medicare HMO Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit www.amerihealthmedicare.com/formulary or call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

SECTION 4 Summary of Important Costs for 2027

	(next year)
Monthly plan premium*	\$0
*Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	

	(next year)
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1.2 for details.)	\$9,850
Primary care office visits	\$0 per visit
Specialist office visits	\$35 per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	Inpatient hospital stay – acute: \$435 per day for days 1-5 per admission \$0 copayment per day for additional days per admission \$2,175 maximum copayment per admission Inpatient hospital stay - mental health: \$410 per day for days 1-5 per admission \$0 copayment per day for additional days per admission \$2,050 maximum copayment per admission

	(next year)
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible Deductible: \$700 for Tier 3, Tier 4, and Tier 5 drugs except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: Drug Tier 1: \$9 Drug Tier 2: \$20 Drug Tier 3: 24% You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: 25% You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% You pay up to \$35 per month supply of each covered insulin product on this tier. Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: Drug Tier 1: \$0 Drug Tier 2: \$0 Drug Tier 3: 24% You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: 25% You pay up to \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% You pay up to \$35 per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

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)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for AmeriHealth Medicare HMO.

Plan Name	Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, and Ocean counties 2027 Monthly Premium
AmeriHealth Medicare Classic Rx HMO	\$0.00

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

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 was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable 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 drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You'll generally have to pay this penalty for as long as you have Part D coverage.

When you first enroll in AmeriHealth Medicare HMO, we let you know the amount of the penalty.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human

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resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.

- **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
- **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is \$41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty be 14% times \$41.33, which equals \$5.78. This rounds to \$5.80. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll generally 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.
- If you're *under* 65 and enrolled in Medicare, 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 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 reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty

before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

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 (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 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 [Medicare.gov/health-drug-plans/part-d/basics/costs](https://www.Medicare.gov/health-drug-plans/part-d/basics/costs).

If you have to pay an extra IRMAA, 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'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your Part D late enrollment penalty

There are five ways you can pay the penalty.

Option 1: Pay by check

Direct Pay – Your monthly premium bill is sent to your home. You write the check payable to AmeriHealth Medicare HMO (not payable to CMS or HHS) and send it directly to us.

If you are enrolled in a plan that charges a monthly premium or you pay the Part D late enrollment penalty, you should be aware of the following:

- You will receive a bill around the 25th day of every month.
- Your premium is due on the 15th day of every month, unless stated otherwise on your bill.
- Your bank may apply a penalty to your account if your check is returned because of insufficient funds.

Checks should be mailed to:
AmeriHealth Medicare HMO
PO Box 825420
Philadelphia, PA 19182-5420

Please do not write any notes or correspondence to us on your premium bill.

Option 2: Pay your premium and/or Part D late enrollment penalty on our website

Direct Pay members who have registered on our website at www.amerihealth.com/login will be able to view and/or pay their invoices directly online when they log in at www.amerihealth.com/login. You can pay directly from your bank account through our member site.

To schedule payments, the user must create a bank account profile and then select a payment date. Payments may be scheduled for a one-time withdrawal or on a recurring monthly basis.

You are excluded from this option if you have selected the following payment options: Electronic Funds Transfer (EFT) (Option 3), direct payment deductions from your monthly Railroad Retirement Board benefit check (Option 4), or direct payment deductions from your monthly Social Security check (Option 5).

For more information regarding this payment option, please contact our Member Help Team.

Option 3: Have your monthly plan premium and/or Part D late enrollment penalties automatically withdrawn from your bank account

Electronic Funds Transfer (EFT) – A fully automatic, computerized way to have your monthly premium or Part D late enrollment penalty payment deducted directly from your bank account.

EFT deductions occur monthly between the 5th and the 15th day of each month. The deduction will not occur on a weekend or bank holiday. At that time, the deduction occurs on the next business day.

If you are interested in the EFT option, please contact our Member Help Team.

After completing the EFT application, please continue to pay your monthly premium or Part D late enrollment penalty directly to the plan until you receive confirmation of enrollment in the EFT program. To avoid overpayment, you can specify a start date for the EFT when you select it as your payment method. If an overpayment does occur, you can request that the amount be refunded or applied as a credit towards your next month's payment. The automated EFT may take up to one to two billing cycles to go into effect from the date of your request for enrollment.

Option 4: Have the plan premium and/or Part D late enrollment penalty taken out of your monthly Railroad Retirement Board (RRB) benefit check

You can have the plan premium or Part D late enrollment penalty taken out of your monthly Railroad Retirement Board (RRB) benefit check. For more information on how to pay this way, please contact our Member Help Team. We will be happy to help you set this up.

Option 5: Have plan premiums and/or Part D late enrollment penalty deducted from your monthly Social Security check

Changing the way you pay your plan premium and/or Part D late enrollment penalty.

If you decide to change how you pay your plan premium and/or Part D late enrollment penalty, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium and/or Part D late enrollment penalty is paid on time. To change your payment method, please contact our Member Help Team or log in at www.amerihealth.com/login to change it directly. If you are new to your plan, you may indicate your payment choice on the enrollment form or call our Member Help Team for assistance.

If you have trouble paying your premium and/or Part D late enrollment penalty

Your plan premium and/or Part D late enrollment penalty is due in our office by the 15th of the month. If we don't get your payment by the 28th of the month, we'll send you a notice letting

you know that your account has a balance due. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your premium and/or Part D late enrollment penalty, if owed, on time, call our Member Help Team at 1 866 569 5190 (TTY/TDD users call 711) to see if we can direct you to programs that will help with your costs.

Section 5.2 Your monthly plan premium won't change during the year

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty.

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

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

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

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

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- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay 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) are 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 has more than 100 employees.
 - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more

Chapter 1 Get started as a member

employees or at least one employer in a multiple employer plan 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, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 AmeriHealth Medicare HMO contacts

For help with claims, billing, or member card questions, call or write to our AmeriHealth Medicare HMO Member Help Team. We'll be happy to help you.

Member Help Team – Contact Information	
Call	1-866-569-5190 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail. Our Member Help Team 1-866-569-5190 (TTY/TDD users call 711) also has free language interpreter services available for non-English speakers.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
Fax	215-761-0300
Write	AmeriHealth Medicare HMO 1901 Market Street Philadelphia, PA 19103
Website	www.amerhealthmedicare.com

How to ask for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services or Part D drugs. For more information on how to ask for coverage decisions about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information

Call	1-866-569-5190 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
Fax	1-888-289-3029 215-238-7960
Write	AmeriHealth Medicare HMO Clinical Precertification 1901 Market Street Philadelphia, PA 19103
Website	www.amerihealthmedicare.com

How to ask for a coverage decision about your Part D Drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your Part D drugs covered under the Part D benefit included in your plan. For more information on how to ask for coverage decisions about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Part D Prescription Drugs – Contact Information

Call	1-888-678-7015 Calls to this number are free. 24 hours a day, 7 days a week. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 24 hours a day, 7 days a week. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
Fax	1-888-671-5285
Write	Prior Authorization Department PO Box 25183 Santa Ana, CA 92799

Coverage Decisions for Part D Prescription Drugs – Contact Information

Website	www.amerihealthmedicare.com
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How to ask for a appeal about your medical care or Part D 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 appeals about your medical care or Part D prescription drugs, see Chapter 9.

Appeals for Medical Care or Part D drugs – Contact Information

Call	1-866-569-5190 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
Fax	1-888-289-3008 215-988-2001
Write	AmeriHealth Medicare HMO Medicare Member Appeals Unit PO Box 13652 Philadelphia, PA 19101-3652
Website	www.amerihealthmedicare.com

How to make a complaint about your medical care

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 doesn't

involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information

Call	1-866-569-5190 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail.
Fax	1-888-289-3008 215-988-2001
Write	AmeriHealth Medicare HMO Medicare Member Appeals Unit PO Box 13652 Philadelphia, PA 19101-3652
Medicare website	To submit a complaint about AmeriHealth Medicare HMO directly to Medicare, go to Medicare.gov/MedicareComplaintForm/home.aspx .

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information	
Call	For medical care claims (Part C): 1-866-569-5190 For prescription drug claims (Part D): 1-888-678-7015 For medical claims (Part C): Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. For prescription drug claims (Part D): Calls to this number are free. 24 hours a day, 7 days a week.
TTY/TDD	711 For medical claims (Part C): Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. For prescription drug claims (Part D): Calls to this number are free. 24 hours a day, 7 days a week.
Fax	1-888-289-3029 215-238-7960
Write	For medical claims (Part C): AmeriHealth Claims Receipt Center PO Box 211184 Eagan, MN 55121 For prescription drug claims (Part D): Part D Payment Requests PO Box 650287 Dallas, TX 75265-0287
Website	www.amerihealthmedicare.com

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about AmeriHealth Medicare HMO: To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In New Jersey, the SHIP is called NJ SHIP.

NJ SHIP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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

NJ SHIP (New Jersey SHIP) – Contact Information

Call	1-800-792-8820 Monday through Friday, 8 a.m. to 5 p.m.
Write	Division of Aging Services New Jersey Department of Human Services PO Box 715 Trenton, NJ 08625-0715
Website	www.state.nj.us/humanservices/doas/home/

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For New Jersey, the Quality Improvement Organization is called Livanta.

Livanta 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. Livanta is an independent organization. It's not connected with our plan.

Contact Livanta in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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.

Livanta: (New Jersey's Quality Improvement Organization) – Contact Information

Call	1-866-815-5440 Monday through Friday, 9 a.m. to 5 p.m., and Saturday and Sunday, 11 a.m. to 3 p.m. 24-hour voicemail service is available.
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701-1105
Website	www.livantaqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. 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, 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. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
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Social Security– Contact Information

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

[SSA.gov](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. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **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 (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact the New Jersey Department of Public Welfare – Office of Medical Assistance Programs (OMAP).

New Jersey Department of Human Services/Division of Medical Assistance and Health Services – Contact Information

Call

1-800-701-0710

Write

NJ Department of Human Services/Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625-0712

Website

<https://www.state.nj.us/humanservices/dmahs/home/>

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website ([Medicare.gov/basics/costs/help/drug-costs](https://www.medicare.gov/basics/costs/help/drug-costs)) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit <https://secure.ssa.gov/i1020/start> to apply online
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- You can request assistance in obtaining this evidence by Calling our Member Help Team. If you already have documentation (e.g., a copy of your Medicaid card or other documentation from the state's Medicaid office), you should send it to:

AmeriHealth Medicare HMO
1901 Market Street
Philadelphia, PA 19103

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the

payment directly to the state. Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) if you have questions.

What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the New Jersey AIDS Drug Distribution Program (ADDP).

Note: To be eligible for the ADAP in your state, people 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, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call New Jersey AIDS Drug Distribution Program at 1-877-613-4533 for more information.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help 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 New Jersey, the State Pharmaceutical Assistance Program is Pharmaceutical Assistance Aged and Disabled (PAAD).

Pharmaceutical Assistance to the Aged and Disabled (PAAD) (New Jersey's State State Pharmaceutical Assistance Program) – Contact Information

Call	1-800-792-9745
Write	Pharmaceutical Assistance to the Aged and Disabled (PAAD) PO Box 715 Trenton, NJ 08625-0715
Website	https://www.nj.gov/humanservices/doas/

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, Call Our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) or visit [Medicare.gov](https://www.medicare.gov).

The Medicare Prescription Payment Plan – Contact Information

Call	1-866-569-5190 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your Call may be sent to voicemail. Our Member Help Team 1-866-569-5190 (TTY/TDD users call 711) also has free language interpreter services for non-English speakers.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Fax	215-761-0300
Write	AmeriHealth Medicare HMO 1901 Market Street Philadelphia, PA 19103
Website	www.amerihealthmedicare.com/ira

SECTION 8 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change

your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number aren’t free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner’s) employer or retiree group, contact **that group’s benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 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 and your cost-sharing amount as payment in full. We 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 only your share of the cost for their 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 Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, AmeriHealth Medicare HMO must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

AmeriHealth Medicare HMO will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get 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) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 3 exceptions:
 - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare 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. Authorization should be received from your plan prior to seeking care. In this situation, you pay the same as you'd pay if you received the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

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

When you become a member of AmeriHealth Medicare HMO, you must choose a network provider as your primary care provider (PCP). All PCPs meet state requirements and are trained to give you basic medical care. A PCP is usually a family or general practitioner or an internist who knows the plan's network and can guide you to a plan specialist when needed. For a list of providers that may act as PCPs, please see the *Provider/Pharmacy Directory*.

See Chapter 4 (Medical Benefits Chart (what is covered and what you pay)) for more information.

Your PCP may also coordinate any additional covered services you receive as a plan member. Coordinating your services includes checking or consulting with other plan (in-network) providers about your care.

In some cases, for specific covered services, your PCP will need to get approval in advance from our plan (this is called getting prior authorization). Please see Chapter 4 for more information on the services that require prior authorization.

Your PCP will provide you with basic medical care and help to arrange or coordinate covered services that you receive as a plan member. These covered services include:

- X-rays;
- Therapies;
- Care from doctors who are specialists; and
- Follow-up care.

As your primary care provider will assist in coordinating and arranging most of your health care services, your PCP has identified specific providers for laboratory services.

You should check with your PCP or call our Member Help Team if you need specific information.

How to choose a PCP

As a AmeriHealth Medicare HMO member, you must select a PCP to coordinate your care. Your PCP must be a part of the AmeriHealth Medicare HMO network. **If you do not select a PCP at the time of enrollment, we will assign one to you.**

Whether you already have a PCP or are searching for one, our *Provider/Pharmacy Directory* will help you confirm if they are in network or help you find one in your plan's network that fits your needs. Our online Find a Provider tool can help you find in-network providers (doctor, hospital, and other medical facilities). Our online Find a Provider tool is available at www.amerihealthmedicare.com/providerfinder.

There are two ways you can select a PCP:

- To select your PCP online, log in or register at www.amerihealth.com/login.
 - **AmeriHealth Medicare HMO** members need to specify their network online to ensure that they are selecting a provider from our list of doctors that are part of their plan's network.

- Or call our Member Help Team, who can assist you in finding and selecting a PCP.

Once you select your PCP, you will receive an updated member ID card with your PCP name, phone number, and laboratory information.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP.

To change your PCP, call our Member Help Team or log in or register at www.amerihealth.com/login. The change will be effective the first day of the month following the request for change. If you call, be sure to inform our Member Help Team representative if you are seeing any specialists or receiving covered services that your PCP approved (such as home health services and durable medical equipment). Our Member Help Team representative will then:

- Help you continue to get specialty care and covered services when you change your PCP;
- Confirm that your chosen PCP is accepting new patients;
- Change your membership record to show the name of your new PCP; and
- Send you a new member ID card that lists the name and phone number of your new PCP.

Section 2.2 Medical care you can get without a PCP referral

You do not need to get a referral from your PCP to see a medical specialist, mental/behavioral health specialist, or other network providers. See section 2.3 for how to get care from specialists and other network providers.

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. For example:

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

You do not need a referral to see a medical specialist, mental/behavioral health specialist, or other network providers.

In some cases, for specific covered services, your PCP or specialist will need to get approval in advance from our plan (this is called getting prior authorization). Please see Chapter 4, Section 2.1 for more information on the services that require prior authorization.

You do not need prior authorization for some services, such as a screening mammogram or screening colonoscopy. In most cases, your radiology site may request a prescription for you to have a screening mammogram. Please check with the facility for specifics.

To find an in-network medical specialist or mental/behavioral health specialist, visit www.amerhealthmedicare.com/directory.

Designated Specialty Sites

PCPs are required to select a designated site that members must use for laboratory services. Members must use their PCP's designated site to receive in-network coverage for laboratory services.

Specialists in designated sites are usually paid a set dollar amount per member per month (capitation) for their services based on the PCPs who have selected them. Before selecting a PCP, you may want to speak to the PCP regarding the designated laboratory sites that the PCP has chosen.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization is required in these instances.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Section 2.4 How to get care from out-of-network providers

AmeriHealth Medicare Classic Rx HMO: 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) 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 requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. To pay the same as you would pay if you got the care from a network provider, you and/or your PCP must obtain prior authorization from the plan prior to seeking care.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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're 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's 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can 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're not part of our network, and worldwide emergency services outside of the United States.
- **As soon as possible, make sure 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. The number to call us is located on the back of your membership ID card.

Covered services in 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 giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're 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'll 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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 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 below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

As a member of AmeriHealth Medicare HMO, you can receive your care from an in-network urgent care facility. See Chapter 4, Section 2.1 for details about copayments. The urgent care facilities in our network can be found in the *Provider/Pharmacy Directory*, on our website at www.amerihealthmedicare.com/directory, or by calling our Member Help Team. As soon as possible, make sure that our plan has been told about your care. We need to follow up on your care. You or someone else should call to tell us about your care, usually within 48 hours. The number to call AmeriHealth Medicare HMO is located on the back of your member ID card.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

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.

You require urgently needed services to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Section 3.3 Get 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're still entitled to care from our plan.

Visit www.amerihealthmedicare.com for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

AmeriHealth Medicare HMO covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. If you pay for services once you reach your benefit limit for those services, or for services not covered by Original Medicare, your out-of-pocket expenses will not count toward your out-of-pocket maximum. You can call our Member Help Team when you want to know how much of your benefit limit you have already used.

SECTION 5 Medical services 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 ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're 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'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need 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 not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you \$10. This makes your net payment for the test \$10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at [Medicare.gov/coverage/clinical-research-studies](https://www.medicare.gov/coverage/clinical-research-studies). You can also call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical 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'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.

- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital, inpatient mental health care, and skilled nursing facility coverage limits will apply. Refer to the Medical Benefits Chart in Chapter 4 for information on these limits.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

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 AmeriHealth Medicare HMO, you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call our Member Help Team 1-866-569-5190 (TTY/TDD users call 711) for more information.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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 don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once

you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage AmeriHealth Medicare HMO 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 AmeriHealth Medicare HMO 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 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of AmeriHealth Medicare HMO. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is:**

- **AmeriHealth Medicare Classic Rx HMO: \$9,850**

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for plan premiums and Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$9,850 for **AmeriHealth Medicare Classic Rx HMO**, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan also limits your out-of-pocket costs for certain types of services

In addition to the maximum out-of-pocket amount for covered Part A and Part B services (described above), we also have a separate maximum out-of-pocket amount that applies only to certain types of services.

Our plan has a maximum out-of-pocket amount per admission for inpatient hospital care:

\$2,175 for **AmeriHealth Medicare Classic Rx HMO**

Once you've paid \$2,175 for **AmeriHealth Medicare Classic Rx HMO** out of pocket for inpatient hospital care, the plan will cover these services at no cost to you for the rest of the inpatient hospital care stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for inpatient hospital care apply to your covered inpatient hospital care.

- **AmeriHealth Medicare Classic Rx HMO:** This means that once you have paid *either* \$9,850 for Part A and Part B medical services *or* \$2,175 for your inpatient hospital care, the plan will cover your inpatient hospital care at no cost to you for the rest of the inpatient hospital care stay.

Our maximum out-of-pocket amount per admission for inpatient mental health care is:

- \$2,050 for **AmeriHealth Medicare Classic Rx HMO**

Once you have paid \$2,050 for **AmeriHealth Medicare Classic Rx HMO** out of pocket for inpatient mental health care, the plan will cover these services at no cost to you for the rest of the inpatient mental health care stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for inpatient mental health care apply to your covered inpatient mental health care.

- **AmeriHealth Medicare Classic Rx HMO:** This means that once you have paid *either* \$9,850 for Part A and Part B medical services *or* \$2,050 for your inpatient mental health care, the plan will cover your inpatient mental health care at no cost to you for the rest of the inpatient mental health care stay.

The Medical Benefits Chart shows the service category out-of-pocket maximums.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Section 1.4 Providers aren't allowed to balance bill you

As a member of AmeriHealth Medicare HMO, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services AmeriHealth Medicare HMO covers and what you pay out of pocket for each service (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these are met:

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B 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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at [Medicare.gov](https://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)**Medical Benefits Chart**

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors. Risk factors for abdominal aortic aneurysm are: • a family history of abdominal aortic aneurysms; • a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime. You're considered at risk if you meet one of the criteria listed above.	There is no coinsurance or copayment, for members eligible for this preventive screening. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered 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 it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments	\$15 copayment per visit for Medicare covered and routine services *Cost sharing for routine acupuncture visits do not count toward your maximum out-of-pocket amount.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Acupuncture for chronic low back pain (continued) may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's 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. Non-Medicare-covered services include: Our plan covers up to six sessions per calendar year for routine acupuncture treatment. Patients must have one of the following conditions to receive routine acupuncture	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Acupuncture for chronic low back pain (continued) services: headache (migraine and tension), post-operative nausea and vomiting, chemotherapy-induced nausea and vomiting, low back pain, chronic neck pain, pain from osteoarthritis of the knee and hip.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be 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.	\$320 copayment per one-way trip by ground or air ambulance. Copayment is not waived if admitted. * Prior authorization is required for non emergency Medicare-covered ambulance. Some restrictions, including destination, may apply. Please note: If you refuse transport when an ambulance is dispatched, the plan will not cover the cost of the ambulance and you will be responsible for the full cost of the service. A round-trip for dialysis may require prior approval.
Annual physical exam You may receive an annual physical examination. The annual physical examination includes a comprehensive review of systems and physical examination, including but not limited to the following: detailed family history, hands-on examination, general appearance, and EKG screening, heart, lung, head, and neck examinations.	There is no coinsurance or copayment for an annual physical exam.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 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 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 <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance or copayment for the annual wellness visit. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
 Bone mass measurement For qualified people (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.	There is no coinsurance or copayment for Medicare-covered bone mass. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
 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	There is no coinsurance or copayment for covered screening mammograms. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Breast cancer screening (mammograms) (continued) Clinical breast exams once every 24 months	If you receive a preventive test that turns into a diagnostic test or service during the procedure, there will be no copayment for that diagnostic test.
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 doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: - Heart attack in the last 12 months - Coronary artery bypass surgery - Stable angina pectoris (chest pain) - Heart valve repair or replacement - Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) - Heart or heart and lung transplant - Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be	\$30 copayment for per provider, per visit for cardiac rehabilitation services \$40 copayment for per provider, per visit for intensive cardiac rehabilitation services

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Cardiac rehabilitation services (continued) spread out over a longer time period. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	
 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.	There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance or copayment for cardiovascular disease testing that is covered once every 5 years. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Caregiver Support Services This program offers training, education, and resources for caregivers. A member's caregiver, or a member who is a caregiver can enroll in the support services through our plan-specified vendor.	\$0 copayment for caregiver support services

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Caregiver Support Services (continued) For more information, contact our Member Help Team.	
 Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance or copayment for Medicare-covered preventive Pap and pelvic exams. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation • Routine chiropractic care, up to six supplemental visits per year • Six routine chiropractic visits include manual manipulation for maintenance chiropractic care.	Manual manipulation: \$15 copayment per visit Routine services: \$15 copayment per visit
 Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening	There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Colorectal cancer screening (continued) colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Colorectal cancer screening (continued) to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth	<i>Medicare-covered dental services</i> \$35 copayment for Medicare-covered dental services <i>Non-Medicare-covered preventive and diagnostic dental services</i> \$0 copayment * Cost sharing for preventive and diagnostic dental services do not count toward your annual maximum out-of-pocket amount.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Dental services (continued) extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover the following non-Medicare covered routine dental services: • One oral exam and cleaning every six months • Two limited problem focused exams every 12 months • One detailed and extensive problem focused exam every 12 months • One comprehensive oral evaluation every 36 months • One comprehensive periodontal evaluation every 36 months • Two dental consultations every 12 months One fluoride treatment every 12 months	You must use a participating AmeriHealth Medicare Dental Network provider for in-network diagnostic, preventive, and comprehensive dental coverage not covered by Original Medicare. Search for a participating AmeriHealth Medicare Dental Network dentist through our Find a Dentist tool at www.amerhealthmedicare.com/findadentist Non-Medicare-covered comprehensive dental services \$1,000 allowance every year for the following comprehensive dental services: restorative services, endodontics, periodontics, extractions, prosthodontics, and other oral/maxillofacial surgery. When the member reaches the \$1,000 annual allowance, the member pays 100% of the cost of services for the rest of the year. 50% coinsurance for the following comprehensive dental services: restorative services, endodontics, periodontics, and simple extractions. 50% coinsurance for the following comprehensive dental services: prosthodontics, and other oral/maxillofacial surgery. \$0 copayment for palliative (emergency) treatment of dental pain, deep sedation/general anesthesia, intravenous moderate (conscious) sedation/analgesia * Cost sharing for non-Medicare- covered diagnostic, preventive, and comprehensive

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Dental services (continued) • One set of dental bitewing X-rays every 12 months • One periapical X-ray every 36 months • One full-mouth series X-ray every 36 months • One panoramic X-ray every 36 months We also cover the following non-Medicare-covered comprehensive dental services: • Restorative Services (Fillings white or silver - one per tooth per surface every 24 months, Crowns - one per tooth every five years. Crown coverage limited to porcelain/ceramic, porcelain fused to metal, $\frac{3}{4}$ and full cast metal crowns.) Core buildup, including any pins when required - 1 per tooth every 5 years. Prefabricated post and core in addition to crown - 1 per tooth every 5 years. All crowns will be paid at the predominately base metal crown and members will be responsible for the difference if a noble, high noble or a titanium crown is placed. Resin-based crowns are not covered services. Endodontics (Root Canals - one per tooth per lifetime, one root canal retreatment per tooth per lifetime, one root canal repair per tooth per lifetime)	dental services do not count toward your annual maximum out-of-pocket amount. If the plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and the alternate treatment will produce a professional satisfactory result; then the maximum amount the plan will pay is for the less expensive treatment. You must use a participating AmeriHealth Medicare Dental Network provider for in-network preventive, diagnostic, and comprehensive dental coverage not covered by Original Medicare. Search for a participating AmeriHealth Medicare Dental Network dentist through our Find a Dentist tool at www.amerihealthmedicare.com/findadentist Reference the preventive/comprehensive dental code list on the plan information page of our website at www.amerihealthmedicare.com.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Dental services (continued) • Periodontics (Four periodontal maintenance procedures every 12 months, one scaling and root planing procedure every 24 months per quadrant, one full-mouth debridement per lifetime) • Simple Extractions (unlimited) • Removable Prosthodontics (One partial, complete or immediate set dentures every five years, one denture adjustment, reline, rebase, or repair every 24 months, one replacement of broken or missing tooth every 24 months, one addition of tooth or clasp to existing partial denture every 24 months, one tissue conditioning per denture per lifetime.) Immediate partial denture – flexible base and removable unilateral partial dentures are not covered. • Fixed Prosthodontics (One set fixed partial dentures every five years, one re-cement or re-bond fixed partial denture every 24 months.) Pontics limited to porcelain/ceramic, porcelain fused to metal and full cast metal services. Retainer crowns limited to resin with metal, porcelain/ceramic and full cast metal services. All pontics and retainer crowns will be paid at the predominately base metal procedure	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Dental services (continued) and members will be responsible for the difference if a noble, high noble or a titanium service is used. Retainer inlays and retainer onlays are not covered services. • Oral and Maxillofacial Surgery (Surgical removal of erupted tooth or residual tooth roots), incision and drainage of abscess, alveoplasty in conjunction with extractions, alveoplasty not in conjunction with extractions (Unlimited) • Deep Sedation/General Anesthesia (As-needed) • Intravenous moderate (conscious) sedation/analgesia (As-needed) • Palliative (emergency) treatment of dental pain (As-needed) All implants and implant related procedures, including implant supported crowns are not a covered service.	
 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.	There is no coinsurance or copayment for an annual depression screening visit. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these 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. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance or copayment for the Medicare-covered diabetes screening tests. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
 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 meter, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and meters • 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-	There is no coinsurance or copayment for beneficiaries eligible for the diabetes self management training preventive benefit. 0% coinsurance for diabetic test strips and blood glucose meters \$0 copayment for lancets and solutions \$0 copayment for custom-molded shoes and inserts \$0 copayment for insulin pumps and related supplies 20% coinsurance for plan-specified continuous glucose monitors and supplies If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Diabetes self-management training, diabetic services, and supplies (continued) customized removable inserts provided with such shoes) including fitting • Diabetes self-management training under certain conditions Test strips and meters must be obtained from preferred vendors Accu-Chek and Contour. Test strips and meters from any other vendor will not be covered. Lancets, solutions, insulin pumps, and related supplies from any brand are available to members. If Accu-Chek and Contour test strips do not work with your current monitor, please call your PCP to request a prescription for a replacement meter. Freestyle Libre and Dexcom are the plan-specified continuous glucose monitoring devices. Note: Dexcom and Freestyle Libre continuous glucose monitor devices and supplies can be purchased at a retail pharmacy. Any other continuous glucose monitor or supplies must be obtained from a Durable Medical Equipment (DME) supplier. Please refer to the DME benefit chart in Chapter 4, Section 2.1.	* Prior authorization is required for select diabetic supplies
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.)	20% coinsurance for Medicare-covered durable medical equipment Your cost sharing for Medicare oxygen

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) Covered items include, but aren't 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. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.amerihealthmedicare.com.	equipment coverage is 20% coinsurance, every month Your cost sharing will not change after being enrolled for 36 months. * Prior authorization is required for certain items. For a list of DME that need precertification/prior authorization, please visit our website at www.amerihealthmedicare.com.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • 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're 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's quickly getting worse.	\$115 copayment per visit \$115 copayment per visit for Worldwide Emergency Coverage Copayment is not waived if admitted to inpatient hospital. If you receive emergency care outside of the United States, you must pay for your care and submit the claim for reimbursement consideration. For details on submitting a reimbursement, see Chapter 9, Section 5.5. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Emergency care (continued) Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency care is covered worldwide. Worldwide ambulance services are not covered.	* Cost sharing for emergency services received outside of the United States do not count toward your maximum out-of-pocket amount.
 Health and wellness education programs Enhanced Disease Management: Services are targeted to members with chronic health conditions. A case manager is assigned to a member following an acute admission. The case manager will focus on educating the member about the condition, reviewing medications, and post-discharge planning. In addition, the case manager will teach the member to recognize early warning signs, and coordinate action with the treating physician if the condition deteriorates. The case manager's activities can include scheduling and tracking of physician appointments or in-home nursing visits, coordinating transportation needs, and installation and monitoring of telemonitoring equipment. Fitness Benefit: Members receive a physical and mental fitness program through a plan specific vendor with the goal of improving general health and well-being. The program includes: • Access to a participating gym network	There is no coinsurance or copayment for health and wellness education programs. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Health and wellness education programs (continued) • On-demand and livestreamed digital content • Home fitness kits include equipment such as resistance bands, yoga mats, and/or exercise tubes • Vendor curated activities that are exercise driven to promote physical activity • Access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass® network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied. For more information, log in or register at www.youronepass.com or call 1-877-504 6830 (TTY/TDD: 711), Monday through Friday, from 9 a.m. to 10 p.m. Health Education: Registered Nurse Health Coaches and Case Managers who are specialized Registered Nurses and Licensed Social Workers periodically assess each member's health care and provide outreach and guidance on a variety of topics. Registered Nurse Health Coaches and Case Managers seek to help members manage their conditions through monitoring, education, teaching self-care, and adopting healthy lifestyle changes.	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Health and wellness education programs (continued) Nursing Hotline: Members can call: 1-888-YOUR-AH1 (1-888-968-7241) (TTY/TDD: 711) 24 hours a day, 7 days a week. Follow the prompts, state Health Coach or Case Manager to reach the first available clinical staff member. The hotline is staffed by nurses who will assist with questions and concerns about all health conditions and will provide support for managing chronic conditions.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. In addition, we cover the following non Medicare-covered routine hearing services: Basic hearing evaluations and hearing aids must be provided by a TruHearing® provider. All hearing services that are not covered by Medicare must be obtained by a TruHearing provider. Any care received from a non participating provider will not be covered by the plan. To obtain routine hearing services, you must contact TruHearing at 1-833-414-9748 (TTY/TDD: 711) Monday through Friday, 8 a.m. to 8 p.m. to schedule an appointment with a participating TruHearing provider. • Routine hearing exams (not covered by Medicare), covered once every year	Medicare-covered hearing services \$35 copayment per visit, per provider type for each Medicare-covered hearing exam Specialist copay applies to Medicare-covered hearing services performed in an office or outpatient setting. Search for in-network providers that provide Medicare-covered hearing services through our Provider Finder at www.amerihealthmedicare.com/providerfinder . Non-Medicare covered routine hearing services \$0 copayment per visit for each routine hearing exam \$699 copayment per year, per ear for Advanced hearing aids; or, \$999 copayment per year, per ear for Premium hearing aids when purchased through TruHearing

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Hearing services (continued) • Unlimited fitting and evaluation for hearing aids for the first year. • Up to two TruHearing-branded hearing aids every year (one per ear, per year). This benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Both Advanced and Premium hearing aids are available in rechargeable style options. You must see a TruHearing provider to use this benefit. Hearing aid services include: ○ 60-day trial period ○ 3-year extended warranty for loss or irreparable damage ○ 80 batteries per aid for non rechargeable models • Benefit does not include or cover any of the following: ○ Ear molds ○ Hearing aid accessories ○ Additional provider visits ○ Additional batteries; batteries when a rechargeable hearing aid is purchased ○ Hearing aids that are not TruHearing branded hearing aids ○ Costs associated with loss and damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	You must use a participating TruHearing provider for in-network routine hearing coverage not covered by Original Medicare. Search for a participating TruHearing provider at www.amerihealthmedicare.com/hearing. There is no coinsurance or copayment for hearing aid fitting and evaluation when obtained by a TruHearing provider. There is no additional cost for optional hearing aid rechargeability. Hearing services and hearing aids received from non participating TruHearing providers and not scheduled through TruHearing are not covered. * Cost sharing for routine hearing services do not count toward your maximum out-of-pocket amount.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Help with certain chronic conditions Personal Emergency Response System (PERS) For qualified members, a medical alert monitoring system will be available that provides 24/7 access to help at the push of a button. Available in multiple styles, including mobile-enabled wearable devices. Eligible members must have a diagnosis of one of the following conditions to be eligible to receive the PERS benefit from the plan-specified vendor: • Dementia • Neurological Disorders (Cerebral Palsy, Multiple Sclerosis and Transverse Myelitis, Muscular Dystrophy, Parkinsons Disease) • Stroke/Transient Ischemic Attack • Fibromyalgia • Chronic Pain and Fatigue • Mobility Impairments • Osteoporosis With or Without Pathological Fracture	Reference the Condition-based Criteria list on the plan information page of our website at www.amerhealthmedicare.com. \$0 copayment for the PERS benefit
 HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover • Up to 3 screening exams during a pregnancy	There's no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Home health agency care Before you get 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 aren't 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	There is no coinsurance or copayment for home health agency care. * Prior authorization is required (includes home infusion therapy). For a definition of Homebound, see Chapter 12.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The 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 aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care	\$0 copayment for home infusion therapy services * Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Home infusion therapy (continued) • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	
Hospice care You're 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. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have 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 When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.	\$0 copayment for a one-time hospice consultation with your primary care provider \$35 copayment for a one-time hospice consultation with a specialist When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not AmeriHealth Medicare HMO For a definition of Respite Care, see Chapter 12.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Hospice care (continued) For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't 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 (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services. • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare For services covered by AmeriHealth Medicare HMO but not covered by Medicare Part A or B: AmeriHealth Medicare HMO will continue to cover plan-	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Hospice care (continued) covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost sharing amount for these services. For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4). Note: If you need non-hospice care (care that's not related to your terminal prognosis), 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.	
 Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you	There is no coinsurance or copayment for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Immunizations (continued) have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Unlimited medically necessary days per admission/stay • Semi-private room (or a private room if 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	\$435 copayment per day for days 1-5 per admission. \$2,175 maximum copayment per admission There is no coinsurance or copayment for additional days per admission. A cost-sharing is charged for each inpatient stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Copayment or coinsurance does not apply for the day of discharge. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Inpatient hospital care (continued) • 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If AmeriHealth Medicare HMO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. If the transplant services above which are listed as part of our network are outside of the community pattern of care, e.g., transplant providers located outside of our plan service area, then you may	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Inpatient hospital care (continued) choose to go to a local transplant provider located within our plan service area, so long as the local transplant providers are willing to accept the Original Medicare rate. For assistance with finding a transplant provider, call our Member Help Team. • Blood — including storage and administration. All components of blood are covered starting with the first pint. • 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're not sure if you're an inpatient or an outpatient, ask the hospital staff. • Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. • Unlimited days each per admission in an acute care hospital	\$410 copayment per day for days 1-5 per admission. \$2,050 maximum copayment per admission There is no coinsurance or copayment for additional days per admission. A cost-sharing is charged for each inpatient stay.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Inpatient services in a psychiatric hospital (continued) • 190-day lifetime benefit maximum for services in a freestanding psychiatric hospital	Copayment or coinsurance does not apply for the day of discharge. *Prior authorization is required.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't 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 body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ,	There is no coinsurance or copayment for inpatient services covered during a non-covered inpatient stay. * Prior authorization is required for select complex radiology, certain durable medical equipment, and prosthetic items. For a list of covered medical services and durable medical equipment that need precertification/prior authorization, please visit our website at www.amerihealthmedicare.com.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay (continued) 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	
 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 the first year you get 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 get 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. Our plan covers up to four additional visits for Medicare-covered medical nutrition	There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services. \$0 copayment for up to four medical nutritional therapy visits for routine medical conditions (non-Medicare) * Medical nutrition therapy requires a physician's order or prescription. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Medical nutrition therapy (continued) therapy for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. Additional four non-Medicare-covered medical nutrition therapy visits for routine medical conditions, such as congestive heart failure (CHF), high blood pressure, high cholesterol, and gluten intolerance.	
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people 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 sustain weight loss and a healthy lifestyle.	There is no coinsurance or copayment for the MDPP benefit. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Medicare Part B drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a	0% coinsurance - 20% coinsurance for Part B drugs, including chemotherapy drugs Up to \$35 copayment for a one-month supply of insulin. Certain Part B Drugs may be subject to Step Therapy. * Prior authorization is required for certain Part B drugs. Please refer to the Precertification List at www.amerhealthmedicare.com/precert or contact our Member Help Team.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Medicare Part B drugs (continued) medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Medicare Part B drugs (continued) supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Medicare Part B drugs (continued) injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: www.amerhealthmedicare.com/partbstep. We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
 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.	There is no coinsurance or copayment for preventive obesity screening and therapy. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get 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) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	\$5 copayment
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't 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	<i>EKG Screening</i> There is no coinsurance or copayment for EKG screening. <i>Laboratory Tests</i> There is no coinsurance or copayment for laboratory tests. Services must be performed at your PCP's designated site, with the exception of approved home sleep studies. <i>Radiation Therapy</i>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) reduce fractures and dislocations • Laboratory tests • Blood — including storage and administration. All components of blood are covered beginning with the first pint used. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests e.g., ultrasounds and sleep studies (home or outpatient)	\$85 copayment per provider, per date of service <i>Complex Radiology (e.g., MRI/MRA, CT scans, nuclear cardiology studies)</i> \$450 copayment per provider, per date of service <i>Routine Radiology (e.g., X-ray, radiology, diagnostic services, ultrasounds)</i> \$40 copayment per provider, per date of service \$0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency, or diagnostic mammogram that results from a preventive mammogram) Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply. *Prior authorization is required for certain items. For a list of covered medical services that need precertification/prior authorization, please visit our website at www.amerihealthmedicare.com
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 Medicare criteria and be considered reasonable and	\$435 copayment per stay for outpatient observation stays Emergency care copayment will apply to any outpatient observation stay of less than 8 hours

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Outpatient hospital observation (continued) necessary. Observation services are covered only when provided by the order of a physician or another person 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're 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 aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
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 aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	\$500 copayment per day for outpatient hospital services See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information. * Prior authorization is required for certain items. For a list of covered medical services that need precertification/prior authorization, please visit our website at

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Outpatient hospital services (continued) • 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 you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.	www.amerhealthmedicare.com . See Colorectal cancer screening for more information about: • Colorectal cancer screening See Durable medical equipment and related supplies for more information about: • Durable medical equipment See Emergency care for more information about: • Emergency room See Medicare Part B prescription drugs for more information about: • Part B drugs See Outpatient diagnostic tests and therapeutic supplies and services for more information about: • Complex radiology (MRI/MRA, CT scans, nuclear cardiology studies) • EKG screening • Laboratory tests • Radiation therapy • Routine radiology (X-ray, radiology, diagnostic services, ultrasounds) See Outpatient mental health care or Outpatient substance abuse services for more information about: • Mental health or substance abuse services

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Outpatient hospital services (continued)	See Outpatient rehabilitation services for more information about: • Rehabilitation therapy (physical, occupational, or speech therapy) See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information about: • Outpatient surgery See Physician/Practitioner services, including doctor's office visits for more information about: • Primary care provider • Specialist See Prosthetic devices and related supplies for more information about: • Prosthetic devices Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply. For a definition of colorectal cancer screening, see Chapter 12 of this document.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed	\$40 copayment for each individual therapy session \$20 for each group therapy session

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Outpatient mental health care (continued) marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. If you receive partial hospitalization benefits, please see Partial hospitalization services for prior authorization restrictions.	* Prior authorization is required for certain services. For a list of covered medical services that need precertification/prior authorization, please visit our website at www.amerihealthmedicare.com
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 outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	\$50 copayment per provider, per date of service for physical therapy and speech therapy \$35 copayment per provider, per date of service for occupational therapy
Outpatient substance use disorder services AmeriHealth Medicare HMO provides outpatient services to help with conditions related to drug or alcohol abuse. Coverage includes care and treatment for alcohol or drug abuse provided by an acute hospital or mental health facility provider. Care and treatment includes, but is not limited to, the diagnosis and treatment of substance	\$40 copayment for each individual therapy session \$20 copayment for each group therapy session

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Outpatient substance use disorder services (continued) misuse, rehabilitation therapy, counseling, and outpatient detoxification by a licensed behavioral health provider (such as a psychiatrist, clinical psychologist, nurse, or certified addiction counselor). If you receive partial hospitalization benefits, please see Partial hospitalization services for prior authorization restrictions.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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.	Ambulatory Surgical Center: \$385 copayment per date of service Outpatient Hospital Facility: \$500 copayment per date of service
Over-the-counter (OTC) items Your AmeriHealth Care Card can be used to purchase eligible over-the-counter (OTC) items in store at participating retail locations. Eligible OTC items include first-aid supplies, vitamins, cold and allergy medicine, and more. You can also use your IBX Care Card to place an order for eligible OTC items by phone or	\$30 quarterly allowance for eligible over-the-counter (OTC) items The AmeriHealth Care Card OTC allowance is provided quarterly (every three months) and does not carry forward to the next quarter if it is not used.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Over-the-counter (OTC) items (continued) online via catalog for delivery through our dedicated vendor. Non-eligible items or items purchased at non-participating retail locations will NOT be covered. Only our vendor/specified online retailer(s) may be used for online orders. If a member exceeds the benefit amount, alternative payment will be required for the remaining balance due. Members should ask the retailer if they accept split payment methods prior to receiving services. For additional details on the OTC benefit, including placing an order, participating retailers, and a list of eligible items, please visit www.amerihealthmedicare.com/carecard or contact our Member Help Team.	
Palliative care Palliative care program offered by our plan will be provided to members and is typically available to individuals 12 to 18 months before end-of-life care (hospice). The palliative care services are home-based and actively manage all aspects of a member's physical health, psychosocial, and spiritual needs. The emphasis of the care program helps to manage pain, stress, and symptom relief. Members have access to a palliative care team 24/7.	\$0 copayment for home-based palliative care services provided through our palliative care case management program. For a definition of Palliative Care, see Chapter 12 of this document.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Partial hospitalization services and Intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	\$35 copayment per provider, per date of service *Prior authorization is required.
Physician/practitioner services, including doctor's office visits Covered services include: - Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location - Consultation, diagnosis, and treatment by a specialist	<i>Primary Care Provider:</i> \$0 copayment for PCP visits <i>Specialist:</i> \$35 copayment per visit \$35 for non-routine Medicare-covered dental services in a specialist office \$35 per visit, per provider type for each Medicare-covered hearing exam

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits (continued) • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: PCP visits; specialist and other health care professional visits; and physical therapy, occupational therapy, and speech therapy visits. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Please check with your health care provider for instructions on how to access their telehealth services, as well as any technology requirements (audio/video). • 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 diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with	<i>Other health care professional:</i> \$35 copayment per visit <i>Physical therapy/speech therapy:</i> \$50 copayment per visit <i>Occupational therapy:</i> \$35 copayment per visit You must use an in-network provider. Additional telehealth services for PCP visits, specialist visits, and physical therapy/occupational therapy/speech therapy received out of network will not be covered.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits (continued) a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • 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 the soonest available appointment • Evaluation of video and/or images you send 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 the soonest available appointment • Consultation your doctor has with	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits (continued) other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery	
Podiatry services 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 • Routine foot care for members, up to six supplemental visits per year (non-Medicare-covered podiatry)	\$20 copayment per visit for Medicare-covered care \$20 copayment per visit for non-Medicare-covered routine care Copayments for non-Medicare routine podiatry visits do not count toward your maximum out-of-pocket amount.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk	There is no coinsurance or copayment for the PrEP benefit.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Pre-exposure prophylaxis (PrEP) for HIV prevention (continued) reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	
 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	There is no coinsurance or copayment for an annual PSA test. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail	20% coinsurance for prosthetics and medical supplies * Prior authorization is required for certain items. For a list of covered medical services that need precertification/prior authorization, please visit our website at www.amerihealthmedicare.com

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
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.	\$25 copayment per provider, per date of service
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (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.	There is no coinsurance or copayment for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
 Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets	There is no coinsurance or copayment for the Medicare-covered counseling and shared decision-making visit or for the LDCT. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. * Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Screening for lung cancer with low dose computed tomography (LDCT) (continued) the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
 Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit	There is no coinsurance or copayment for the Medicare-covered screening for the Hepatitis C Virus. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Screening for Hepatitis C virus infection (continued) injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	
 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 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.	There is no coinsurance or copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their	Inpatient dialysis: No additional copayment or coinsurance for inpatient dialysis when received during an inpatient hospital stay Outpatient dialysis: 20% coinsurance

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Services to treat kidney disease (continued) care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 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're 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 Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.	Kidney disease education services: There is no coinsurance or copayment for kidney disease education services. If performed at the provider's office, only dialysis coinsurance should apply.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing	\$0 copayment per day for days 1 - 20 \$221 copayment per day for days 21-100

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) facilities are sometimes called SNFs.) 100 days per Medicare benefit period. A prior hospital stay is not required. Covered services include but aren't 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 our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • 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	A benefit period is the way that both our plan and Original Medicare measure your use of hospital and skilled nursing facility (SNF) services. Our plan uses benefit periods for skilled nursing facility stays, but we do not use benefit periods to measure inpatient hospital stays. 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 an 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.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for 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 or domestic partner is living at the time you leave the hospital	
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling	There is no coinsurance or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued) We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	
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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques	\$20 copayment per visit

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Supervised exercise therapy (SET) (continued) 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.	
Telemedicine visits Teladoc Health must be used for telemedicine visits. You have convenient and confidential access to quality board-certified, U.S.-licensed doctors for non-emergent general medical visits, mental/behavioral health visits, and dermatology consultations through Teladoc. Connect virtually from the comfort of your home via your computer, tablet, or smartphone. Additional telehealth services received from other in-network providers will include an in-office copay. Not all services can be provided as a telehealth visit. See the Physician/Practitioner services, including doctor's office visits section of medical benefits chart for more information on covered additional telehealth services. General Medical 24/7 Care Visits 24/7 access to talk to a doctor for non-emergency conditions like the flu, allergies, coughs, sore throats, rashes and more. Visits can be scheduled by calling 1-800-835-2362 (TTY/TDD: 711), online at	General Medical 24/7 Care Visits (focused on non-emergent medical conditions by connecting to a state-licensed physician) \$0 copayment per visit

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Telemedicine visits (continued) the same Dermatology provider each time. Members must complete a comprehensive medical history assessment, either online or by telephone with a designated Teladoc Health representative, prior to receiving telemedicine services. <i>Teladoc Health is not available internationally.</i>	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgently needed services are covered worldwide. For a list of network urgent care centers, please call our Member Help Team.	Retail Clinic: \$5 copayment Urgent care center: \$40 copayment Worldwide urgent care: \$115 copayment Copayment not waived if admitted to inpatient hospital. For a definition of Retail Clinic, see Chapter 12 of this document. If you receive emergency care outside of the United States, you must pay for your care, and submit the claim for reimbursement consideration. For details on submitting a reimbursement, see Chapter 9, Section 5.5. *Cost sharing for urgently needed services received outside of the United States do not count toward your maximum out-of-pocket amount and are not waived if admitted.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Vision care 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 for glaucoma, we 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 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 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. • Our plan covers the Medicare-covered standard frames and lenses for cataracts up to the Medicare allowed amount.	Medicare-covered vision care \$35 copayment for each Medicare-covered eye exam There is no coinsurance or copayment for a diabetic retinal eye exam or dilated retinal eye exam. There is no coinsurance or copayment for Medicare-covered glaucoma screenings. There is no coinsurance or copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. Search for in-network providers that provide Medicare-covered vision care through our Find a Provider tool at www.amerihealthmedicare.com/providerfinder Non-Medicare-covered routine vision care \$0 copayment for one routine eye exam every year If you purchase glasses (eyeglass frames and lenses) in the Davis Vision Collection, frames

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Vision care (continued) NOTE: Upgrades such as deluxe frames, progressive lenses, and additional lens upgrades (including but not limited to transition, scratch-resistant, or tinted lenses) are not covered for glasses/lenses after cataract surgery. You may pay for upgrades yourself if you choose. In addition, we cover the following non-Medicare-covered routine vision services: • One routine eye exam (not covered by Medicare) covered every year. • Eyewear: one pair of eyeglass frames and lenses, or contact lenses in lieu of frames and lenses. Covered every year. Our plan does not cover lens upgrades, including but not limited to: transition, progressive, polish, scratch-resistant, or tinted lenses, or vision/lens insurance.	and lenses are covered in full. If you purchase glasses (frames and lenses) outside of the Davis Vision Collection but at a Davis Vision provider, you are covered up to \$100. If you purchase glasses (frames and lenses) from Visionworks, you are covered up to \$200. You are covered up to \$100 per year for contact lenses in lieu of routine eyewear (frames and lenses). * Cost sharing for non-Medicare-covered routine vision services do not count toward your maximum out-of-pocket amount. You must use a participating Davis Vision network provider for in-network routine vision coverage not covered by Original Medicare. Search for a participating Davis Vision network providers at www.amerihealthmedicare.com/davisvision
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B.	There is no coinsurance or copayment for the <i>Welcome to Medicare</i> preventive visit. If you receive a separate additional non preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Welcome to Medicare preventive visit (continued) When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)**SECTION 3 Services that aren't covered by our plan (exclusions)**

This section tells you what services are excluded from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered 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 get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't 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 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances. Routine non-Medicare-covered services: Covered for headache (migraine and tension), postoperative nausea and vomiting, chemotherapy induced nausea and vomiting, low back pain, chronic neck pain, pain from osteoarthritis of the knee and hip
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
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities	Not covered under any condition

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
of daily living, such as bathing or dressing.	
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 (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care Your plan may include some non-Medicare-covered comprehensive dental services. Please go to the Dental services row in the Medical Benefits Chart for further detail
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 for people with diabetic foot disease

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital.	Covered only when medically necessary
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Routine eye exams and eyewear
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered Routine supplemental visits, up to six per year, are covered
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). Routine supplemental visits, up to six per year, are covered.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Worldwide ambulance services	Not covered under any condition

CHAPTER 5:

Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's 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. (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (www.amerihealth.com/medicare/get-care/find-a-drug.html), and/or call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider/Pharmacy Directory* will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, get help from our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) or use the Pharmacy Directory. You can also find information on our website at www.amerihealth.com/medicare/get-care/find-a-drug.html.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).
- 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 restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Pharmacy Directory* www.amerihealth.com/medicare/get-care/find-a-drug.html or call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

Section 2.2 Our plan's mail-order service

Our plan's mail-order service allows you to order **at least a 90-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 please call our Member Help Team and ask about our mail-order pharmacy service provided by OptumRx® Home Delivery or visit www.amerihealthmedicare.com.

Usually, a mail-order pharmacy order will be delivered to you in no more than 7 to 10 days. If we anticipate a delay in shipment, OptumRx® Home Delivery will contact you as soon as a delay is discovered.

New prescriptions the pharmacy gets directly from your doctor's office.

After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or stop 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 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 before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or 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, contact your pharmacy 7 to 10 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, contact us by calling OptumRx® Home Delivery at 1-888-678-7015 (TTY/TDD users call 711) or log in at www.amerihealth.com/login.

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

Our plan offers 2 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 (which offer preferred cost sharing) at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case

you'll be responsible for the difference in price. Your *Provider/Pharmacy Directory* www.amerihealth.com/medicare/get-care/find-a-drug.html tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) for more information.

2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- Covered Part D drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling outside of our plan's service area where there is no network pharmacy. We may cover your prescription at an out-of-network pharmacy for up to a 30-day supply if at least one of the following applies:
 - If the prescriptions are related to care for a medical emergency or urgent care;
 - If you are unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service;
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high-cost and unique drugs). You may have to pay more than your normal cost-sharing amount and will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement. We will consider your request and make a coverage decision. If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost.
- We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on [Medicare.gov](https://www.medicare.gov), along with the specific medical conditions that they cover.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. 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. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Five cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Cost-Sharing Tier 1: preferred generic (lowest cost-sharing tier)
- Cost-Sharing Tier 2: generic
- Cost-Sharing Tier 3: preferred brand (includes both brand-name and generic drugs)
- Cost-Sharing Tier 4: non-preferred drug (includes both brand-name and generic drugs)
- Cost-Sharing Tier 5: specialty tier (highest cost-sharing tier)

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (www.amerihealthmedicare.com/formulary). The Drug List on the website is always the most current.
- Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (www.amerihealthmedicare.com/pharmacyfinder) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our 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, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on 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 example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you 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. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we 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 don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) or on our website www.amerhealth.com/medicare/get-care/find-a-drug

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 1-866-569-5190

(TTY/TDD users call 711) or on our website www.amerithealth.com/medicare/get-care/find-a-drug

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's 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 you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take that isn't on our Drug List has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

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

- **If you're a new member**, we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.

- **If you were in our plan last year**, we'll 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 a 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-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.
- If a transition occurs due to a member changing settings, such as moving from a home residence to a long-term facility and then back again, AmeriHealth Medicare HMO has a method in place to ensure that you have access to your medication. If your change of setting cannot be identified by the automated system, the pharmacy can notify AmeriHealth Medicare HMO of the setting change and provide you with your needed medications. You will receive notice that you must either switch to a therapeutically appropriate drug on the plan's formulary or request an exception to continue taking the requested drug.

For questions about a temporary supply, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

During the time when you're 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 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) 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.

Option 2. You can ask for an exception

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

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we'll authorize coverage for the drug before the change takes effect.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) 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.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our specialty tier (Tier 5) aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**

- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

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

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 regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
 - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We'll tell you at least 30 days before we make the change, or tell you about the change and cover an 30-day fill of the version of the drug you're taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
 - Sometimes a drug can 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 take that drug, we'll tell you after we make the change.
- **Making 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 based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you take. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you take. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're 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 won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- 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 take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll 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 drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- Non-prescription 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 requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will

automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't 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. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

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

Section 9.2 As 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 its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it's part of our network.

Check your *Pharmacy Directory* www.amerihealthmedicare.com/directory to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that your plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in a Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide 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

We conduct drug use reviews to help make sure our members get 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 like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar 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're allergic to
- Possible errors in the amount (dosage) of a drug you take

- Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use 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 prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be 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 prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers 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'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage 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 our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely may be able to get services through an MTM program. If you qualify for the 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 get 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 get 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. 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'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent 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, call our Member Help Team at 1-866-569-5190 (TTY/TDD users 711) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (www.amerithealthmedicare.com/pharmacyfinder), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,400, the Part D EOB will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for AmeriHealth Medicare HMO members

There are **3 drug payment stages** for your drug coverage under AmeriHealth Medicare HMO. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits* (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 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's how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't 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, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
 - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
 - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your

out-of-pocket costs. 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 get the *Part D EOB* look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You'll pay a yearly deductible of \$700 on Tier 3, 4 and 5 drugs. **You must pay the full cost of your** Tier 3, 4 and 5 drugs until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you have paid \$700 for your Tier 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has five cost-sharing tiers

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1: preferred generic (lowest cost-sharing tier)
- Cost-Sharing Tier 2: generic
- Cost-Sharing Tier 3: preferred brand (includes both brand-name and generic drugs)
 - You pay up to \$35 per month supply of each covered insulin product on this tier
- Cost-Sharing Tier 4: non-preferred drug (includes both brand-name and generic drugs)

- You pay up to \$35 per month supply of each covered insulin product on this tier
- Cost-Sharing Tier 5: specialty tier (highest cost-sharing tier)
 - You pay up to \$35 per month supply of each covered insulin product on this tier

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers standard cost sharing.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider/Pharmacy* www.amerihealth.com/medicare/get-care/find-a-drug.html.

Section 5.2 Your costs for a one-month supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a one-month supply of a covered Part D drug

AmeriHealth Medicare Classic Rx HMO					
Tier	Standard retail cost sharing in-network (up to a 30-day supply)	Preferred retail cost sharing in-network (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost Sharing Tier 1 (Preferred Generics)	\$9 Copayment	\$0 Copayment	\$0 Copayment	\$9 Copayment	\$9 Copayment
Cost Sharing Tier 2 (Generics)	\$20 Copayment	\$0 Copayment	\$0 Copayment	\$20 Copayment	\$20 Copayment
Cost Sharing Tier 3 (Preferred Brand)	24% Coinsurance	24% Coinsurance	24% Coinsurance	24% Coinsurance	24% Coinsurance
Cost Sharing Tier 4 (Non-Preferred Drugs)	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance
Cost Sharing Tier 5 (Specialty Tier)	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible if you have one.

Go to Section 7 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply, if this will help you plan refill dates better.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 90-day, but no more than a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day, but no more than a 100-day supply.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *long-term* (up to a 90-day, but no more than a 100-day) supply of a covered Part D drug

AmeriHealth Medicare Classic Rx HMO			
Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (up to a 90-day supply)
Cost Sharing Tier 1* (Preferred Generics)	\$18 Copayment	\$0 Copayment	\$0 Copayment
Cost Sharing Tier 2 (Generics)	\$40 Copayment	\$0 Copayment	\$0 Copayment
Cost Sharing Tier 3 (Preferred Brand)	24% Coinsurance	24% Coinsurance	24% Coinsurance
Cost Sharing Tier 4 (Non-Preferred Drugs)	25% Coinsurance	25% Coinsurance	25% Coinsurance
Cost Sharing Tier 5 (Specialty Tier)	A long-term supply isn't available for drugs in Tier 5.	A long-term supply isn't available for drugs in Tier 5.	A long-term supply isn't available for drugs in Tier 5.

*Tier 1 drugs are available for a 100-day supply.

You won't pay more than \$70 for up to a 2-month supply or \$105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible if you have one. You won't pay more than \$70 if you fill a 3-month supply of a covered insulin product through our mail-order pharmacy even if you haven't paid your deductible if you have one.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the \$2,400 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccines are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.

Chapter 6 What you pay for Part D drugs

- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

To ensure full access to your Part D vaccine benefit for a vaccine that is not an adult ACIP recommended vaccine, we encourage you to receive your vaccine and have it administered at a network pharmacy. Because there may be a large difference between the amount your doctor charges you and the amount we normally pay, you may not receive reimbursement for the full amount you paid out of pocket when you choose scenario 2 or 3 above.

CHAPTER 7:

Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

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

Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
- If you pay the entire amount yourself at the time you get 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 made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

- If the provider is owed anything, we'll pay the provider directly.
- If you already paid more than your share of the cost of the service, we'll 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 shouldn't pay

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

- You only have to pay your cost-sharing amount when you get covered services. We don't 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's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our 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 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 fill a prescription

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 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. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

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

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll 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'll 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 9 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask 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 12 months** of the date you got the service, item, or drug.

To make sure you're 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'll help us process the information faster.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

- Download a copy of the form from our website (www.amerihealthmedicare.com) or call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) and ask for the form.

Whether you choose to use the form or not, the following information is needed in order for us to identify you and process your request for payment:

- Member name
- Member ID number (located on your member ID card)
- Member date of birth
- Date of service
- Procedure code (located on the bill or receipt from the provider)
- Diagnosis code (located on the bill or receipt from the provider)
- Billed charges/amounts
- Provider name and National Provider Identifier (NPI)
- Receipt or proof of payment

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

For medical payment requests (Part C):

AmeriHealth Claims Receipt Center
PO Box 211184
Eagan, MN 55121

For prescription drug payment requests (Part D):

Part D Payment Requests
PO Box 650287
Dallas, TX 75265-0287

SECTION 3 We'll consider your request for payment and say yes or no

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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 9.

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, 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 our plan can meet these accessibility requirements include, but aren't 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 data CD, in large print, or in audio formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

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 our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with our Member Help Team. You can 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.

SECCIÓN 1 Nuestro plan debe respetar sus derechos y sensibilidades culturales

Sección 1.1 Debemos proporcionar información de una manera que funcione para usted y de acuerdo con sus sensibilidades culturales (en idiomas que no sean inglés, en braille, en español, en letra grande u otros formatos alternativos, etc.)

Nuestro plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de forma culturalmente competente y sean accesibles a todos los afiliados, incluidos los que tienen un dominio limitado del inglés, capacidad limitada de lectura, incapacidad auditiva o diversos orígenes culturales y étnicos. Los ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traductor, servicios de intérprete, máquinas de escribir o conexión TTY (teléfono de texto o teléfono teletipo).

Nuestro plan cuenta con servicios gratuitos de interpretación disponibles para responder preguntas de miembros que no hablan inglés. Si lo necesita, también podemos proporcionarle información en braille, en CD de datos, en letra grande o en formatos de audio sin coste alguno. Estamos obligados a facilitarle información sobre los beneficios de nuestro plan en un formato accesible y adecuado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame nuestro Asociado Ayuda del equipo en 1-866-569-5190 (Las llamadas de los usuarios de TTY/TDD 711).

Nuestro plan debe brindar a las afiliadas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para mujeres.

Si los proveedores de la red de nuestro plan para una especialidad no están disponibles, es responsabilidad de nuestro plan localizar proveedores de la especialidad fuera de la red que le proporcionen la atención necesaria. En este caso, solo pagará los gastos compartidos dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran un servicio que necesita, llame a nuestro plan para informarse sobre dónde acudir para obtener este servicio a un costo compartido dentro de la red.

Si tiene algún problema para obtener información sobre nuestro plan en un formato que sea accesible y adecuado para usted, para consultar a un especialista en salud femenina o para encontrar un especialista de la red, llame para presentar una queja a nuestro Equipo de Atención para Asociados. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. If you don't select a PCP, we'll auto assign you a PCP as indicated in Chapter 3, Section 2.1. We don't require you to get referrals to go to network providers.

You have the right to get appointments and covered services from our 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 you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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 Practice*, 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 don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D 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's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

AmeriHealth is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

The Notice of Privacy Practices describes how AmeriHealth may use and disclose a member's personal health information and how a member of an AmeriHealth health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit www.amerihealthmedicare.com/privacy. You can also call to request a copy of the Notice of Privacy Practices by contacting our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of AmeriHealth Medicare HMO you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711):

- **Information about AmeriHealth and our plan.** This includes, for example, information about our 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.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're 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. 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's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** 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're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the New Jersey Department of Health. You may call the Complaint Hotline at 1-800-792-9770 or use the online form at <https://www.nj.gov/health/healthcarequality/patients-families/file-complaint-how-to/>.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we’re required to treat you fairly.**

Section 1.7 If you believe you’re being treated unfairly, or your rights aren’t being respected

You have the right to be treated with fairness, respect, and recognition of your dignity. If you believe you’ve been treated unfairly or your rights haven’t been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services’ **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you’ve been treated unfairly or your rights haven’t been respected, *and it’s not* about discrimination, you can get help dealing with the problem you’re having from these places:

- **Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711)**
- **Call your local SHIP** at 1-800-783-7067
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call our plan’s Member Help Team at 1-866-569-5190 (TTY/TDD users call 711)**
- **Call your local SHIP** at 1-800-783-7067
- **Contact Medicare**
 - Visit [Medicare.gov](https://www.medicare.gov) to read the publication *Medicare Rights & Protections* (available at: [Medicare Rights & Protections](#))
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)
- You also have the right to make recommendations regarding our rights and responsibilities policy by calling our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For, questions, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

- **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's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
 - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors, other providers, and AmeriHealth 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 you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
 - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
 - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
 - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
 - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.

- **If you move *within* our plan 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* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

SECTION 3 Member communications

Section 3.1 Member connections

There are many ways that you can connect with our plan and manage your health care coverage, whether on paper or online.

Health Needs Assessment

A health risk assessment survey is available online that helps us learn more about your health care needs. The information provided will not affect your enrollment in the plan or your premium.

Personal Health Visit

Personal health visits are a convenient way to get personalized health assessment and advice in the comfort of your home and are offered to you **at no extra cost**. This service is optional, does not affect your current health insurance benefits or premiums, and does not replace your annual wellness visit.

Member Site

Log in or register at www.amerihealth.com/login anytime and anywhere to find all your health and benefit information in one place. Access your member ID card, the Provider/Pharmacy Finder, the status of recent claims, and important messages. You can also manage your prescription drug benefit, search lower-cost alternatives, and order and track medications through mail-order home delivery service. You can also visit our website at www.amerihealthmedicare.com for plan documents, health and wellness information, and more.

Find a Doctor or Hospital

Our online *Find a Provider* tool helps you find an in-network provider. You can search for medical providers and facilities within the tool at www.amerihealthmedicare.com/providerfinder. The information about network providers available on the *Find a Provider* tool includes:

- Name, address, and telephone numbers
- Professional qualifications

- Specialty
- Medical school attended
- Residency completion
- Board certifications status
- Languages spoken, gender, race, and/or ethnicity

Medical Technology Assessment

Our plan uses the technology assessment process to assure that new drugs, medical procedures, behavioral health procedures, or devices are safe and effective before approving them as a covered service. When new technology becomes available, or, at the request of a practitioner or member, the plan researches all scientific information available from these expert sources. Following this analysis, the plan:

- Decides about when a new drug, procedure, or device has been proven to be safe and effective; and
- Uses this information to determine when an item becomes a covered service.

The review and evaluation of available clinical and scientific information is done by expert sources. These sources include, but are not limited to:

- Publications from government agencies;
- Peer-reviewed journals;
- Professional guidelines;
- Regional and national experts;
- Clinical trials; and
- Manufacturers' literature.

Section 3.2 Utilization management reviews

The professional providers, independent medical consultants, medical directors, or nurses that perform utilization review services are not compensated or given incentives based on coverage review decisions. Medical directors and nurses are salaried and contracted external physicians and other professional consultants are compensated on a per case-reviewed basis, regardless of the coverage determination. The health benefit plan does not specifically reward or provide financial incentives for issuing denials of coverage. There are no financial incentives for such individuals, which would encourage utilization review decisions that result in underutilization.

CHAPTER 9:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- 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).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

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

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help you understand which process you should use to handle a problem you're having. They can also answer 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 for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit [Medicare.gov](https://www.Medicare.gov).

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

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Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuse to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide whether medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete the review, we will 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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help 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:

- **Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at www.amerihealthmedicare.com.)
 - For medical care or Part B drugs, your doctor can ask for 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.
 - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** 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 person to be your representative, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at www.amerihealthmedicare.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

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- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-866-569-5190 (TTY/TDD users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

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2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've 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 5.3.**

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, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision**Legal Terms:**

A coverage decision that involves your medical care 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 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

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If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.

If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to your prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get 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 calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll 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. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

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- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal**Legal Terms:**

An appeal to our 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 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll 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 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're 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 65 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

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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 asking for an appeal.

- **You can ask for a copy of the information regarding your medical decision. 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 our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request.
- We'll gather more information if needed, and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - 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'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.

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- 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process**Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't 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: The independent review organization reviews your appeal.

- We'll 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**.
- 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 the information about your appeal.

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If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets 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**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets 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**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down**

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your appeal.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your 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.
- Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed 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 the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

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To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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 asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 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. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **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 don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't 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 Term:**

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'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception.**

Section 6.2

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- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception**Legal Terms:**

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd 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 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4 (non-preferred drugs). You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the 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. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

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3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty tier).
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically 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're asking for and wouldn't cause more side effects or other health problems, we generally *won't* approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

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 our 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.

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- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception**Legal term:**

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 get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get yet. (You can't 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'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll 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 asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask 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* or on our plan's form, which is available on our website www.amerihealthmedicare.com. Chapter 2 has contact information. Visit www.amerihealthmedicare.com to locate and complete our plan's form. To help us process

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your request, include your name, contact information, and information that shows 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 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for 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 give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
 - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.

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- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 get your request.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal**Legal Terms:**

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**.

A fast appeal is called an **expedited redetermination**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision, we made about a drug you didn't get yet, 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.

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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 or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-866-569-5190.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website www.amerihealthmedicare.com. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 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 asking for 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 give you our answer.

- When we review your appeal, we take another careful look at all 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 get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.

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- **If our answer is no to part or all of what you asked for**, we'll 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 didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll 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 already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 6.6 How to make a Level 2 appeal**Legal Terms:**

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

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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 independent review organization.
 - **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- 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 the information about 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 independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

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Step 3: The independent review organization gives you its answer.***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent 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're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent 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**. It's also called **turning down your appeal**.). In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells 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 3 additional levels in the appeals process after Level 2 (for a total of 5 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't 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 our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) or 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get 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 discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.

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- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you 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 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) or 1-800 MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048. You can also get the notice online at [CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 who are 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 aren't 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 got (*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.

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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 can 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 don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll 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 our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1-877-486-2048.) Or you can get a sample notice online at [CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-mail](https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-mail).

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll 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 independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

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- You'll 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 independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 7.3 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 its 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 your coverage for the care ends.

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 the information about your appeal.

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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 independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your 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's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**Section 8.1 We'll tell you in advance when your coverage will be ending****Legal Term:**

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- 1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to ask for a fast-track appeal to ask 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 got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 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'll 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, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711). Or call your State Health Insurance Assistance Program, (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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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 got (*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*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization, using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll 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's medically necessary.**

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- You'll 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 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, **you'll 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 8.3 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 calendar 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 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 the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.***What happens if the independent review organization says yes?***

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.

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- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent 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 want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 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 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's 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's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.

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- If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we'll 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 medical care 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 the decision that turns down your appeal, the appeals process is over.
 - If you don't 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'll 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 medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll 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 don't 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all 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 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's 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 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 get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't 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 get the decision.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't 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 who 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 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.

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and 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 got (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 Member Help Team? • Do you feel you're being encouraged to leave our plan?

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
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 Member Help Team or other staff at our 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 about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or 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 10.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a **complaint** is called **filing a grievance**.

Using the **process for complaints** is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: Contact us promptly – either by phone or in writing.

- **Calling our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) is usually the first step.** If there's anything else you need to do, our Member Help Team will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.

Here is our formal procedure for answering grievances:

- Standard Grievance Process

If we can't resolve your issue over the phone, we have a formal procedure to review your issues. To use the formal grievance procedure, please call: 1-866-569-5190 (TTY/TDD: 711) 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, mail a written request to AmeriHealth Medicare HMO, Medicare Member Appeals Unit, PO Box 13652, Philadelphia, PA 19101-3652. You will receive notification of the resolution of your grievance.

- Expedited (Fast) Grievance Process

As a member, you may file an expedited grievance with AmeriHealth Medicare HMO for the following reasons only:

- We decided to invoke an extension to, or reconsidered the time frames for, an organization determination ; and/or
- We refused to grant your request for an expedited organization determination or reconsideration, or coverage determination or redetermination.

We only respond within 24 hours of receiving your expedited grievance request if it is for a valid reason. To file an expedited grievance, please call 1-866-569-5190 (TTY/TDD: 711), 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, mail a written request to AmeriHealth Medicare HMO, Medicare Member Appeals Unit, PO Box 13652, Philadelphia, PA 19101-3652.

You can also submit your complaint to us by fax (see Chapter 2 for more information).

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll 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.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

- **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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 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 10.4 You can also tell Medicare about your complaint

You can submit a complaint about AmeriHealth Medicare HMO directly to Medicare. To submit a complaint to Medicare, go to [Medicare.gov/my/medicare-complaint](https://www.medicare.gov/my/medicare-complaint). You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in AmeriHealth Medicare HMO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs and you'll 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 can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open 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 coverage:
 - Another Medicare health plan, with or without drug coverage,
 - Original Medicare *with* a separate Medicare drug plan, or
 - Original Medicare *without* a separate Medicare drug plan.
 - If you choose this option, and receive Extra Help Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same 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 drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of AmeriHealth Medicare HMO may be eligible to end their 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. These are just examples. For the full list you can contact our plan, call Medicare, or visit [Medicare.gov](https://www.Medicare.gov):

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're 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.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're 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 drug coverage,
- Original Medicare *with* a separate Medicare drug plan, or
- Original Medicare *without* a separate Medicare drug plan.

Note: If you disenroll from Medicare 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.

- **Your membership will usually end** on the first day of the month after we get your request to change your plan.
- **If you get Extra Help from Medicare to pay your drugs coverage costs:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from AmeriHealth Medicare HMO when your new plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare <i>with</i> a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from AmeriHealth Medicare HMO when your new drug plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	• Send us a written request to disenroll Call Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227), and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from AmeriHealth Medicare HMO when your coverage in Original Medicare starts.

SECTION 4 Until your membership ends, you must keep getting your medical items, services, and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 AmeriHealth Medicare HMO must end your plan membership in certain situations

AmeriHealth Medicare HMO must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.

- If you're away from our service area for more than 6 months.
 - If you move or take a long trip, call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or national, or an eligible noncitizen
- 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're enrolling in our plan and that information affects your eligibility for our plan. (We can't 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 can't 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're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership call our Member Help Team at 1-866-569-5190 (TTY/TDD users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

AmeriHealth Medicare HMO isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

Section 5.2 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 11:

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, (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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, 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, 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 [HHS.gov/ocr/index.html](https://www.hhs.gov/ocr/index.html).

If you have a disability and need help with access to care, call us at our Member Help Team 1-866-569-5190 (TTY/TDD users call 711). If you have a complaint, such as a problem with wheelchair access, our Member Help Team 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, AmeriHealth Medicare HMO, 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 Notice about reporting fraud, waste, and abuse

Health care fraud, waste, and abuse are violations of state and/or Federal law. The AmeriHealth Corporate and Financial Investigations Department helps to protect members and providers from fraudulent and abusive practices. If you know of or suspect health insurance fraud, waste, or abuse, please report it. You are not required to provide identifying information about yourself when reporting fraud, waste, and abuse. Call the toll free Fraud Hotline at 1-866-282-2707.

SECTION 5 Additional information about Medicare Secondary Payer subrogation rights

AmeriHealth Medicare HMO is subrogated to all your rights against any party legally liable to pay for your injury, illness, or medical expenses. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, liability insurance, umbrella insurance, or any other form or type of insurance. AmeriHealth Medicare HMO may assert this right independently of you. However, AmeriHealth Medicare HMO is not obligated in any way to pursue this right independently or on behalf of you but may choose to pursue its rights to reimbursement from you under the plan, at its sole discretion. AmeriHealth Medicare HMO's subrogation/reimbursement right is the first priority, and the full amount of medical expenses that were paid by AmeriHealth Medicare HMO must be repaid in full before funds are allotted toward any other form of damages, regardless of whether you are fully compensated for other damages. In cases of occupational illness or injury, AmeriHealth Medicare HMO's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include AmeriHealth Medicare HMO's interest and AmeriHealth Medicare HMO shall be reimbursed in first priority from any such award or settlement.

You or anyone acting legally on your behalf must:

- Fully cooperate with AmeriHealth Medicare HMO to protect AmeriHealth Medicare HMO's subrogation/reimbursement rights;
- Give notice of AmeriHealth Medicare PPO's claim to third parties and their insurers who may be legally responsible;
- Provide AmeriHealth Medicare HMO with relevant information, and sign and deliver such documents as AmeriHealth Medicare HMO reasonably request to secure AmeriHealth Medicare HMO's subrogation/reimbursement claim;
- Request AmeriHealth Medicare HMO's consent before releasing any party from liability for medical expenses or services paid or provided; and

Chapter 11 Legal notices

- Fully reimburse AmeriHealth Medicare HMO or its designated representative immediately upon receiving compensation from a third party, regardless of how the compensation is described or designated.'

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, AmeriHealth Medicare HMO's subrogation/reimbursement rights. In other words, you must not do anything or take any steps to jeopardize the recovery rights of AmeriHealth Medicare HMO.

SECTION 6 Notice of Privacy Practices

AmeriHealth is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures. The Notice of Privacy Practices describes how AmeriHealth may use and disclose a member's personal health information and how a member of an AmeriHealth health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit www.amerihealthmedicare.com/privacy. You can also call to request a copy of the Notice of Privacy Practices by contacting our Member Help Team at the number on the back of this document.

CHAPTER 12:

Definitions

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 doesn't 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 got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of AmeriHealth Medicare HMO, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. Our plan uses benefit periods for skilled nursing facility stays, but we do not use benefit periods to measure inpatient hospital stays. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

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 that begins when you (or other qualified parties on your behalf) have spent \$2,400 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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 MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't 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 gotten. (This is in addition to our plan's monthly premium.) Cost sharing includes any combination of the following 3 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 gotten; 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 gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're 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 our plan, that isn't a coverage determination. You need to call or write to our

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 the prescription drugs covered by our plan.

Covered Services – The term we use to mean all 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 don't need skilled medical care or skilled nursing care. Custodial care provided by people who don't 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.

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're 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 our 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 people 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 person's eligibility.

Dually Eligible Individual – A person who is eligible 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

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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're 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 isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare 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's approved by the 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 doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't 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).

Home Health Care Setting – A location at which you primarily reside and receive certain health care services. Home health care can include care given by skilled medical professionals, including skilled nursing care, physical therapy, occupational therapy, and

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speech therapy. Custodial care, as defined in this document, can also be received in a home health care setting. Medicare does not cover custodial care provided in a home health care setting.

Homebound – Leaving your home is not recommended because of your condition; or, your condition keeps you from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or, leaving home takes a considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

Hospice - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're 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 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out of pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. In addition to the maximum out-of-pocket amount for in-network covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

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 FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get 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 3-month period after a person 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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a 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 Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't 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 our 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. 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).

Member Help Team – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

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**.

Non-Participating Provider – A provider that is not contracted with Medicare and does not accept Medicare assignments.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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 Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like 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 2 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 doesn't 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 aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our

plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to 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 as covered Part D drugs 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 plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's 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're first eligible to join a Part D plan.

Per Year – Refers to the period in which you have health care coverage and can obtain services covered under your plan. This period is between January 1, 2027, and December 31, 2027. This is also known as the "plan year," "contract year," "benefit year," or "coverage year."

Pharmacy Benefit Manager – An entity that administers prescription drugs on behalf of our plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred)

providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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 and/or certain drugs based on specific criteria. 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 and our criteria are posted on our website.

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 a drug 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.

“Real-Time Benefit Tool” – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Respite Care – A temporary institutional care of a dependent elderly, ill, or handicapped person, which provides relief for their usual caregivers.

Retail Clinic – A type of walk-in clinic located in a supermarket, pharmacy, or retail store where members can receive preventive care or treatment for uncomplicated minor illnesses in a nonemergency setting.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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 (non-emergency) services. Our plan must disenroll you if you permanently move out of our 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 Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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 live 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'll 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically

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necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Website URL – The address of a resource (such as a document or website) on the Internet. URL stands for “uniform resource locator” or a “universal resource locator.”

Benefits underwritten by AmeriHealth HMO, Inc.

Dental benefits underwritten by AmeriHealth HMO, Inc.

Vision benefits are underwritten by AmeriHealth HMO, Inc. and administered by Davis Vision, an independent company.

One Pass is a voluntary program offered by an independent company. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program.

OptumRx is an Optum® company – an independent company that provides home delivery, specialty, and infusion pharmacy services.

OTC Network®, OTC Network® app, and CVS Health are provided by InComm Payments™, an independent company.

Teladoc Health and the practitioners accessible through Teladoc Health are independent companies and contractors not affiliated with AmeriHealth. Please consult a physician for personalized medical advice. Always seek the advice of a physician or other qualified health care provider with any questions regarding a medical condition.

TruHearing® is a registered trademark of TruHearing, Inc., an independent company.

AmeriHealth Medicare HMO Member Help Team

Method	Customer Service– Contact Information
Call	1-866-569-5190 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Our Member Help Team 1-866-569-5190 (TTY/TDD users call 711) also has free language interpreter services available for non-English speakers.
TTY/TDD	711 Calls to this number are free. Same hours as the phone number above.
Fax	215-761-0300
Write	AmeriHealth Medicare HMO 1901 Market Street Philadelphia, PA 19103
Website	www.amerihealthmedicare.com

NJ SHIP (New Jersey's SHIP)

NJ SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
Call	1-800-792-8820
Write	NJ SHIP Division of Aging Services PO Box 715 Trenton, NJ 08625-0715
Website	www.state.nj.us/humanservices/doas/home/

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