

January 1 – December 31, 2022

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of *VillageCareMAX Medicare Total Advantage (HMO D-SNP)*

This booklet gives you the details about your Medicare and Medicaid health care and prescription drug coverage from January 1 – December 31, 2022. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, *VillageCareMAX Medicare Total Advantage (HMO D-SNP)*, is offered by *Village Senior Services Corporation (VillageCareMAX)*. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means *Village Senior Services Corporation*. When it says “plan” or “our plan,” it means *VillageCareMAX Medicare Total Advantage (HMO D-SNP)*).

This document is available for free in Spanish and Chinese.

Please contact our Member Services number at 1-800-469-6292 for additional information. (TTY users should call 711). Hours are 7 days a week, from 8:00 am to 8:00 pm.

You can get this information for free in other formats, such as large print, braille, or audio. Call 1-800-469-6292 (TTY: 711), during the hours of 8:00 am to 8:00 pm, 7 days a week.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2023.

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

VillageCareMAX is an HMO plan with Medicare and New York State Medicaid contracts. Enrollment in VillageCareMAX depends on contract renewal.

You can also contact the Independent Consumer Advocacy Network (ICAN). ICAN is the ombudsman program for health plan members. ICAN can answer your questions and give you free, independent advice about your coverage, complaints, and appeal options. All services are free. ICAN can be reached at 1-844-614-8800 (TTY: 711), or online at www.icannys.org and ican@cssny.org.

VillageCareMAX complies with Federal civil rights laws and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Out-of-network/non-contracted providers are under no obligation to treat VillageCareMAX Medicare Total Advantage members, except in emergency situations. Please call Member Services or read this Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Multi-Language Insert

Multi-Language Interpreter Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-469-6292; TTY/TDD: 711.	English
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Table of Contents

2022 Evidence of Coverage**Table of Contents**

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member	5
Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
Chapter 2. Important phone numbers and resources	18
Tells you how to get in touch with our plan (<i>VillageCareMAX Medicare Total Advantage</i>) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
Chapter 3. Using the plan's coverage for your medical and other covered services	38
Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.	
Chapter 4. Medical Benefits Chart (what is covered and <i>what you pay</i>)	55
Gives the details about which types of medical care are covered and <i>not</i> covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.	
Chapter 5. Using the plan's coverage for your Part D prescription drugs	96
Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's <i>List of Covered Drugs (Formulary)</i> to find out which drugs are covered. Tells which kinds of drugs are <i>not</i> covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.	
Chapter 6. What you pay for your Part D prescription drugs	120
Tells about "Extra Help" and getting help from Medicare to help pay for your prescription drug plan costs.	

Chapter 7. Asking us to pay a <i>bill you have received</i> for covered medical services or drugs	122
Explains when and how to send a bill to us when you want to ask us to pay you back for your covered services or drugs.	
Chapter 8. Your rights and responsibilities	130
Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	142
Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
<ul style="list-style-type: none">• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.	
Chapter 10. Ending your membership in the plan.....	199
Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
Chapter 11. Legal notices	210
Includes notices about governing law and about nondiscrimination.	
Chapter 12. Definitions of important words	221
Explains key terms used in this booklet.	
Chapter 13. VillageCareMAX Medicaid Advantage Plus (MAP) Member Handbook	231

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1	Introduction	6
Section 1.1	You are enrolled in <i>VillageCareMAX Medicare Total Advantage</i> , which is a specialized Medicare Advantage Plan (Special Needs Plan).....	6
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?	6
Section 1.3	Legal information about the <i>Evidence of Coverage</i>	6
SECTION 2	What makes you eligible to be a plan member?	7
Section 2.1	Your eligibility requirements	7
Section 2.2	What are Medicare Part A and Medicare Part B?	8
Section 2.3	What is Medicaid?	8
Section 2.4	Here is the plan service area for <i>VillageCareMAX Medicare Total Advantage</i>	8
Section 2.5	U.S. Citizen or Lawful Presence	9
SECTION 3	What other materials will you get from us?	9
Section 3.1	Your plan membership card – Use it to get all covered care and prescription drugs	9
Section 3.2	The <i>Provider and Pharmacy Directory</i> : Your guide to all providers in the plan’s network	10
Section 3.3	The <i>Provider and Pharmacy Directory</i> : Your guide to pharmacies in our network	11
Section 3.4	The plan’s List of <i>Covered Drugs (Formulary)</i>	12
Section 3.5	The <i>Part D Explanation of Benefits</i> (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs	12
SECTION 4	Your monthly premium for <i>VillageCareMAX Medicare Total Advantage</i>	12
Section 4.1	How much is your plan premium?	12
Section 4.2	Can we change your monthly plan premium during the year?	14
SECTION 5	Please keep your plan membership record up to date	14
Section 5.1	How to help make sure that we have accurate information about you	14
SECTION 6	We protect the privacy of your personal health information	15
Section 6.1	We make sure that your health information is protected	15
SECTION 7	How other insurance works with our plan	15
Section 7.1	Which plan pays first when you have other insurance?	15

SECTION 1 Introduction

Section 1.1	You are enrolled in <i>VillageCareMAX Medicare Total Advantage (HMO D-SNP)</i>, which is a specialized Medicare Advantage Plan (Special Needs Plan)
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You are covered by both Medicare and Medicaid:

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

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, *VillageCareMAX Medicare Total Advantage*.

There are different types of Medicare health plans. *VillageCareMAX Medicare Total Advantage* is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. *VillageCareMAX Medicare Total Advantage* is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Medicaid also provides other benefits to you by covering health care services including long term care and home and community based services that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. VillageCareMAX Medicare Total Advantage will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

VillageCareMAX Medicare Total Advantage is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the New York State Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage, long term care and home and community based services.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility

requirement. Please visit the Internal Revenue Service (IRS) website at:
www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare and Medicaid medical care, long term care and home and community based services, and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care, long term care and home and community based services, and the prescription drugs available to you as a member of *VillageCareMAX Medicare Total Advantage*.

It’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan’s Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It’s part of our contract with you

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

The contract is in effect for months in which you are enrolled in *VillageCareMAX Medicare Total Advantage* between January 1, 2022 and December 31, 2022.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *VillageCareMAX Medicare Total Advantage* after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Chapter 1. Getting started as a member

Medicare must approve our plan each year

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

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- and -- You live in our geographic service area (Section 2.4 below describes our service area)
- -- and -- you are a United States citizen or are lawfully present in the United States
- -- and -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Full Medicaid Benefits. In addition, you must be eligible for nursing home level of care and show a need and require one of the following Community Based Long Term Care Services (CBLTCS) for a continuous period of more than 120 days from the effective date of enrollment:

- Nursing services in the home
- Therapies in the home
- Health aide services in the home
- Personal care services in the home
- Consumer directed personal assistance services
- Adult day health care
- Private duty nursing

Please note: If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within three-months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Chapter 1. Getting started as a member

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 What is Medicaid?

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

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

- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part B premiums, in some cases Medicare Part A premiums, and full Medicaid benefits.

Section 2.4 Here is the plan service area for *VillageCareMAX Medicare Total Advantage*

Although Medicare is a Federal program, *VillageCareMAX Medicare Total Advantage* is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in *New York*: Bronx, Kings (Brooklyn), New York (Manhattan) and Queens.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.5 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify *VillageCareMAX Medicare Total Advantage* if you are not eligible to remain a member on this basis. *VillageCareMAX Medicare Total Advantage* must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Here's a sample membership card to show you what yours will look like:

SAMPLE

Front of Member Identification Card

VILLAGECAREMAX	
VillageCareMAX Medicare Total Advantage (HMO D-SNP)	
Member Name: <FName> <LName>	MedicareRx Prescription Drug Coverage
Member ID: <Subscriber ID #>	
Health Plan (80840): 7538162273	
Effective Date: <Enrollment Date>	
PCP Name: <PCP Name>	RxBin: 015574
PCP Phone: <PCP Phone>	RxPCN: ASPROD1
	RxGRP: VCM02
Copays: See your Evidence of Coverage for information on cost sharing. Medicaid COB applies. Visit www.villagecaremax.org for more info.	
CMS Contract #: H2168 002	

Back of Member Identification Card

This card does not guarantee coverage. In an emergency, call 911 or go to the nearest emergency room.		
Member Services:	1-800-469-6292	(TTY: 711)
Physician Call Line:	1-844-484-7362	(TTY: 711)
Pharmacy Services:	1-888-807-6806	(TTY: 711)
Vision Services:	1-800-879-6901	(TTY: 711)
Dental Services:	1-888-442-8878	(TTY: 1-877-855-8039)
Website:	www.villagecaremax.org	
Provider Services: 1-855-769-2500		
Send Claims To: ILS – VillageCare, PO Box 21516, Eagan, MN 55121		
Change Healthcare Electronic Payer ID: 26545		

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your *VillageCareMAX Medicare Total Advantage* 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 routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your *VillageCareMAX Medicare Total Advantage* membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2	The <i>Provider and Pharmacy Directory</i>: Your guide to all providers in the plan's network
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The *Provider and Pharmacy Directory* lists our network providers and durable medical equipment suppliers. If a provider in our network accepts Medicaid, we will list “M” next to the provider’s name in the Provider and Pharmacy Directory.

What are “network providers”?

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. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.villagecaremax.org.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which VillageCareMAX Medicare Total Advantage authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

It is important that you know the participating providers who accept Medicaid. You must go to Medicaid providers to receive Medicaid covered services that are not covered by Medicare. If you do not go to a Medicaid provider, you may be responsible for payment.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider and Pharmacy Directory* at www.villagecaremax.org, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3	The Provider and <i>Pharmacy Directory</i>: Your guide to pharmacies in our network
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What are “network pharmacies”?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated Provider and Pharmacy Directory is located on our website at www.villagecaremax.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2022 Provider and Pharmacy Directory to see which pharmacies are in our network.**

If you don’t have the *Provider and Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.villagecaremax.org.

Section 3.4	The plan’s List of Covered Drugs (<i>Formulary</i>)
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The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered under the Part D benefit included in *VillageCareMAX Medicare Total Advantage*. In addition to the drugs covered by Part D, some prescription drugs are covered for you under your Medicaid benefits. The Drug List tells you how to find out which drugs are covered under Medicaid.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the *VillageCareMAX Medicare Total Advantage* Drug List.

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

You can call Member Services to request a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.villagecaremax.org) or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.5	The <i>Part D Explanation of Benefits</i> (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs
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When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the “Part D EOB”).

The *Part D Explanation of Benefits* tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefit is used. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 5 (*Using the plan’s coverage for your Part D prescription drugs*) gives more information about the Part D EOB.

The *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for *VillageCareMAX Medicare Total Advantage*

Section 4.1	How much is your plan premium?
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You do not pay a separate monthly plan premium for *VillageCareMAX Medicare Total Advantage* because you receive full extra help. Members with Medicare and Medicaid get their Part D premium paid completely by extra help.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. This situation is described below.

- Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
 - If you receive “Extra Help” from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.
 - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage.
- Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium.

Some members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *VillageCareMAX Medicare Total Advantage* members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- 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. If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be. If you had a life-changing event that caused your income to go down, you can ask Social Security to reconsider their decision.
- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan.**
- You can also visit www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of the *Medicare & You 2022* handbook gives information about these premiums in the section called "2022 Medicare Costs." Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You 2022* handbook from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2	Can we change your monthly plan premium during the year?
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No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

SECTION 5	Please keep your plan membership record up to date
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Section 5.1	How to help make sure that we have accurate information about you
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

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

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you

have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter).

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
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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.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?
--

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

*Important phone numbers
and resources*

Chapter 2. Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1	<i>VillageCareMAX Medicare Total Advantage</i> contacts (how to contact us, including how to reach Member Services at the plan).....	19
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program)	27
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)	28
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)	29
SECTION 5	Social Security	30
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)	31
SECTION 7	Information about programs to help people pay for their prescription drugs	33
SECTION 8	How to contact the Railroad Retirement Board	35
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	36

SECTION 1 ***VillageCareMAX Medicare Total Advantage* contacts**
(how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to *VillageCareMAX Medicare Total Advantage* Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-800-469-6292 Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
FAX	212-337-5711
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014
WEBSITE	www.villagecaremax.org

How to contact us when you are asking 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 will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-469-6292 Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
FAX	212-337-5711
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014
WEBSITE	www.villagecaremax.org

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Medical Care – Contact Information
CALL	1-800-469-6292 Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
FAX	1-347- 226-5180
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014
WEBSITE	www.villagecaremax.org

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	1-800-469-6292 Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm.
FAX	347-226-5180
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014
MEDICARE WEBSITE	You can submit a complaint about <i>VillageCareMAX Medicare Total Advantage</i> directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-888-807-6806 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-858-790-7100
WRITE	MedImpact Healthcare Systems, Inc. Attention: PA Department, 10181 Scripps Gateway Ct, San Diego, CA 92131
WEBSITE	www.villagecaremax.org

Chapter 2. Important phone numbers and resources

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-888-807-6806 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-858-790-6060
WRITE	MedImpact Healthcare Systems, Inc. Attention: Appeals/Grievance Department, 10181 Scripps Gateway Ct, San Diego, CA 92131
WEBSITE	www.villagecaremax.org

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-888-807-6806 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-858-790-6060
WRITE	MedImpact Healthcare Systems, Inc. Attention: Appeals/Grievance Department, 10181 Scripps Gateway Ct, San Diego, CA 92131
MEDICARE WEBSITE	You can submit a complaint about <i>VillageCareMAX Medicare Total Advantage</i> directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Chapter 2. Important phone numbers and resources

Method	Payment Request for Medical Care – Contact Information
CALL	1-800-469-6292. 7 days a week from 8:00 am to 8:00 pm Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week from 8:00 am to 8:00 pm
FAX	212-337-5711
WRITE	VillageCareMAX ILS – VillageCare P.O Box 21516 Eagan, MN 55121
WEBSITE	www.villagecaremax.org
Method	Payment Request for Part D Prescription Drugs – Contact Information
CALL	1-888-807-6806 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	MedImpact Healthcare Systems, Inc. P.O. Box 509108 San Diego, CA 92150-9010
WEBSITE	www.villagecaremax.org

Chapter 2. Important phone numbers and resources

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 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 with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans.

Chapter 2. Important phone numbers and resources

Method	Medicare – Contact Information
WEBSITE (continued)	<p>You can also use the website to tell Medicare about any complaints you have about <i>VillageCareMAX Medicare Total Advantage</i>:</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about <i>VillageCareMAX Medicare Total Advantage</i> directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance Program (HIICAP).

Health Insurance Information, Counseling and Assistance Program (HIICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Health Insurance Information, Counseling and Assistance Program (HIICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HIICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Chapter 2. Important phone numbers and resources**METHOD TO ACCESS SHIP and OTHER RESOURCES:**

- Visit www.medicare.gov
- Click on “**Forms, Help, and Resources**” on far right of menu on top
- In the drop down click on “**Phone Numbers & Websites**”
- You now have several options
 - Option #1: You can have a **live chat**
 - Option #2: You can click on any of the “**TOPICS**” in the menu on bottom
 - Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York’s SHIP) – Contact Information
CALL	1-800-701-0501
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	2 Lafayette Street, 7 th Floor New York, NY 10007-1392
WEBSITE	www.aging.ny.gov/healthbenefits/

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New York, the Quality Improvement Organization is called Livanta.

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

Chapter 2. Important phone numbers and resources

You should contact Livanta in any of these situations:

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

Method	Livanta BFCC (New York's Quality Improvement Organization) – Contact Information
CALL	1-866-815-5440
FAX	1-833-868-4056
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program, Area 1 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.BFCCQIOArea1.com

SECTION 5 Social Security

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

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

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

Chapter 2. Important phone numbers and resources

Method	Social Security – Contact Information
CALL	<p>1-800-772-1213</p> <p>Calls to this number are free.</p> <p>Available 7:00 am to 7:00 pm, Monday through Friday.</p> <p>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</p>
TTY	<p>1-800-325-0778</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Available 7:00 am to 7:00 pm, Monday through Friday.</p>
WEBSITE	www.ssa.gov

SECTION 6**Medicaid**

(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year. Individuals from the following group is eligible for enrollment in VillageCareMAX Medicare Total Advantage:

- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part B premiums, in some cases Medicare Part A premiums, and full Medicaid benefits.

VillageCareMAX Medicare Total Advantage is a Dual Eligible Special Needs (D-SNP) Plan. We cover both your Medicare and Medicaid benefits under one plan. VillageCareMAX Medicare Total Advantage has a contract with the Centers of Medicare & Medicaid Services (CMS) to provide your Medicare benefits under the Medicare Advantage program. The Plan also has a contract with New York State Department of Health (NYSDOH) to provide your Medicaid benefits under the Medicaid Advantage Plus (MAP) program. All enrollment requests must be approved by both CMS and NYSDOH in order for an individual to be completely enrolled in the VillageCareMAX Medicare Total Advantage Plan.

If you have questions about the assistance you get from Medicaid, contact the New York City Human Resources Administration/Department of Social Services (HRA/DSS).

Chapter 2. Important phone numbers and resources

Method	New York City Human Resources Administration/Department of Social Services (HRA/DSS) – Contact Information
CALL	1-888-692-6116 Available 8:00 am to 5:00 pm, Monday through Friday
WRITE	785 Atlantic Avenue Brooklyn, NY 11238
WEBSITE	www.nyc.gov/hra

The New York State Office for the Aging (NYSOFA) helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	New York State Office for the Aging (NYSOFA) – Contact Information
CALL	1-800-342-9871
WRITE	New York State Office for the Aging 2 Empire State Plaza Albany, NY 12223-1251
WEBSITE	www.aging.ny.gov

The New York State Office of Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	New York State Office of Long Term Care Ombudsman Program – Contact Information
CALL	1-855-582-6769
WRITE	Long Term Care Ombudsman Program Two Empire State Plaza Albany, New York NY 12223-1251
WEBSITE	www.ltombudsman.ny.gov

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

Medicare's "Extra Help" Program

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

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

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

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

- You should call Member Services at the phone number located on the back cover of this booklet for assistance. You will be required to provide us with evidence that will help determine your correct copayment level. The documents that can be used as evidence include (but are not limited to) copies of Medicaid card, New York State document that confirms Medicaid status, or an award letter from Social Security Administration.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage

Chapter 2. Important phone numbers and resources

gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. New York State residents can get access to ADAP by contacting the New York State HIV Uninsured Care Programs at 1-800-542-2437. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. You can contact the New York State HIV Uninsured Care Programs at 1-800-542-2437.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

What if you get “Extra Help” from Medicare to help pay your prescription drug costs?**Can you get the discounts?**

Most of our members get “Extra Help” from Medicare to pay for their prescription drug plan costs. If you get “Extra Help,” the Medicare Coverage Gap Discount Program does not apply to you. If you get “Extra Help,” you already have coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn’t appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048

State Pharmaceutical Assistance Programs

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

In New York, the State Pharmaceutical Assistance Program is the Elderly Pharmaceutical Insurance Coverage (EPIC).

Method	Elderly Pharmaceutical Insurance Coverage (EPIC) (New York's State Pharmaceutical Assistance Program) – Contact Information
CALL	1-800-332-3742
TTY	1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	EPIC P.O. Box 15018 Albany, NY 12212-5018
WEBSITE	www.health.ny.gov/health_care/epic

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Chapter 2. Important phone numbers and resources

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0”, you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	rrb.gov/

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits or premiums. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan or enrollment periods to make a change.

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

CHAPTER 3

*Using the plan's coverage for your
medical and other covered services*

Chapter 3. Using the plan's coverage for your medical and other covered services

Chapter 3. Using the plan's coverage for your medical and other covered services

SECTION 1	Things to know about getting your medical care and other services covered as a member of our plan	40
Section 1.1	What are “network providers” and “covered services”?	40
Section 1.2	Basic rules for getting your medical care and other services covered by the plan	40
SECTION 2	Use providers in the plan's network to get your medical care and other services	41
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your care	41
Section 2.2	What kinds of medical care and other services can you get without getting approval in advance from your PCP?	43
Section 2.3	How to get care from specialists and other network providers	43
Section 2.4	How to get care from out-of-network providers	44
SECTION 3	How to get covered services when you have an emergency or urgent need for care or during a disaster	45
Section 3.1	Getting care if you have a medical emergency	45
Section 3.2	Getting care when you have an urgent need for services	46
Section 3.3	Getting care during a disaster	47
SECTION 4	What if you are billed directly for the full cost of your covered services?	47
Section 4.1	You can ask us to pay for covered services	47
Section 4.2	What should you do if services are not covered by our plan?	48
SECTION 5	How are your medical services covered when you are in a “clinical research study”?	48
Section 5.1	What is a “clinical research study”?	48
Section 5.2	When you participate in a clinical research study, who pays for what?	49
SECTION 6	Rules for getting care covered in a “religious non-medical health care institution”	50
Section 6.1	What is a religious non-medical health care institution?	50
Section 6.2	Receiving Care From a Religious Non-Medical Health Care Institution	50

Chapter 3. Using the plan's coverage for your medical and other covered services

SECTION 7	Rules for ownership of durable medical equipment	51
Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?	51
SECTION 8	Rules for Oxygen Equipment, Supplies, and Maintenance	52
Section 8.1	What oxygen benefits are you entitled to?	52
Section 8.2	What is your cost-sharing? Will it change after 36 months?	52
Section 8.3	What happens if you leave your plan and return to Original Medicare?	52

Chapter 3. Using the plan's coverage for your medical and other covered services

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

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

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

Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

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

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and Medicaid health plan, *VillageCareMAX Medicare Total Advantage* must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare. See Chapter 4 for a list of covered services.

VillageCareMAX Medicare Total Advantage will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered 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.

Chapter 3. Using the plan's coverage for your medical and other covered services

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - Referrals are not required as a member of our plan. A referral is approval from your PCP to see another provider.
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare or Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In most cases, you will be required to get prior authorization from the plan before seeking care from an out-of-network provider. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your care
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What is a "PCP" and what does the PCP do for you?

- *What is a PCP?*

Your Primary Care Provider or PCP is a physician, nurse practitioner, or other health care professional who meets state requirements and is trained to give you basic medical care. You will get routine or basic medical care from your PCP. He or she makes sure you get the care you need to keep you healthy. You must choose a network provider to be your PCP when you become a member of our plan.

Chapter 3. Using the plan's coverage for your medical and other covered services

- *What types of providers may act as a PCP?*

You can choose a PCP from several types of providers. These include general practitioners, family practitioners, nurse practitioners; and specialists who agree to serve the role as a primary care provider.

- *What is the role of the PCP in our plan?*

Your PCP will provide you with most of your routine and preventive medical care. He or she will help coordinate many of the covered services you get as a member of our plan. These include hospital admissions, diagnostic tests such as x-rays, laboratory tests, therapies, specialist visits, and follow-up care.

When your PCP “coordinates” covered services, this includes following up with other plan providers about your care, identifying services that you need, and making sure that services are meeting your specific health needs.

In some cases, your PCP will need to get prior authorization (prior approval) from us for certain types of covered services or supplies. Please see the Benefits Chart in chapter 4 for a complete list of covered benefits and prior authorization rules.

How do you choose your PCP?

You will have to choose one of our network providers who is accepting new patients to be your PCP. You can also view the most current list of providers on our website at www.villagecaremax.org or call to request a hard copy of the Provider & Pharmacy Directory. Please contact Member Services to tell us about your selection or if you need assistance with selecting a PCP (phone numbers for Member Services are printed on the back cover of this booklet). Once you choose your PCP, the change will take effect within 5 to 10 business days. We will update your membership record with the PCP information and mail you a new Member ID card. The name and office phone number of your PCP will be printed on your Member ID card.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. If you change your PCP, this will not limit you to the providers that you can see in our network. VillageCareMAX does not require you to get a referral from your PCP to see other providers in the network.

To change your PCP, call Member Services to request a new PCP (contact information is on the back cover of this booklet). Member Services will check to see if the PCP is accepting new patients. Once a new PCP is selected, we will update your membership record with the new PCP information and effective date. A new Member ID card will be mailed that shows the new PCP name and office phone number.

Chapter 3. Using the plan's coverage for your medical and other covered services

If you select an in-network PCP, VillageCareMAX will let you know if your PCP leaves the network and will help you choose another PCP. If you are undergoing a course of treatment for a specific illness or injury, please call Member Services about transitional care. In some cases, we may authorize a transitions period for you to continue to receive services from the provider who is leaving the network until you complete your current course of treatment.

Section 2.2	What kinds of medical care and other services can you get without getting approval in advance from your PCP?
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations
- Emergency services from network providers or from out-of-network providers
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 2.3	How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

You do not need a referral from your PCP to see a specialist in our network. You can get these services on your own or your PCP can provide you with assistance if you need help selecting a specialist. If you need additional services, your PCP or specialist will need to get "prior authorization" (approval in advance) from VillageCareMAX for certain services including some diagnostic tests, home health services, and durable medical equipment. Please refer to the Benefits Chart in Chapter 4 for a complete listing of all services that require prior authorization.

Chapter 3. Using the plan's coverage for your medical and other covered services

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

For assistance, please call us toll free at 1-800-469-6292 (TTY: 711) during the hours of 8:00 am to 8:00 pm, 7 days a week.

Section 2.4	How to get care from out-of-network providers
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You must use network providers to get covered services except for emergency care, urgently needed care or out-of-area renal dialysis. In these cases, prior authorization to get treatment from an out-of-network provider is not required. If you need medical care that Medicare requires our plan to cover and providers in our network cannot provide this care, you can get these services from an out-of-network provider. In this case, you must contact Member Services to obtain prior authorizations for non-emergent care. If the plan authorizes out-of-network services, your cost-sharing for the out-of-network services will be the same as if you had received your care from a network provider.

Chapter 3. Using the plan's coverage for your medical and other covered services

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

Section 3.1	Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You may notify us by calling Member Services at 1-800-469-6292 (TTY: 711) from 8:00 am to 8:00 pm, 7 days a week. This contact number is also listed on the back of your Member ID card and on the back cover of this booklet.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and worldwide emergency/urgent coverage. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

Medicare does not provide coverage for emergency medical care outside the United States and its territories. However, VillageCareMAX Medicare Total Advantage Plan provides additional coverage for Worldwide Emergency/Urgent Coverage outside of the United States and its territories. For more information, see the Medical Benefit Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care

Chapter 3. Using the plan's coverage for your medical and other covered services

is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

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

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

Section 3.2	Getting care when you have an urgent need for services
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What are “urgently needed services”?

“Urgently needed services” are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

If you need urgently needed services, call your PCP or go to the nearest urgent care center. If you need assistance, you can also call Member Services during business hours. Our number is printed on the back cover of this booklet. You can speak to a physician 24 hours per day about non-emergency health related concerns by calling our Physician Call Line at 1-844-484-7362 (TTY: 711).

Chapter 3. Using the plan's coverage for your medical and other covered services

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

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

- To furnish emergency services, and needed to evaluate or stabilize an emergency medical condition
- Non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care

Please refer to the Benefit Chart in Chapter 4 of this booklet for more details.

Section 3.3	Getting care during a disaster
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If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.villagecaremax.org for information on how to obtain needed care during a disaster.

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

SECTION 4	What if you are billed directly for the full cost of your covered services?
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Section 4.1	You can ask us to pay for covered services
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If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

Chapter 3. Using the plan's coverage for your medical and other covered services

Section 4.2 What should you do if services are not covered by our plan?

VillageCareMAX Medicare Total Advantage covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized. Before paying for the cost of a service not covered by *VillageCareMAX Medicare Total Advantage*, you should check if the service is covered by Medicaid and can be accessed by using your Medicaid card.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." *VillageCareMAX Medicare Total Advantage* has an annual Maximum Out-of-Pocket limit of \$6,700. Because you get assistance from Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered services. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Chapter 3. Using the plan's coverage for your medical and other covered services

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

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

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study. Please see Chapter 7 for more information about submitting requests for payment.

Chapter 3. Using the plan's coverage for your medical and other covered services

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication “Medicare and Clinical Research Studies” (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1	What is a religious non-medical health care institution?
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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 will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2	Receiving Care From a Religious Non-Medical Health Care Institution
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

Chapter 3. Using the plan's coverage for your medical and other covered services

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

Medicare inpatient hospital limits do not apply. Plan covers unlimited additional days. Please see the Benefits Chart in Chapter 4 for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

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 *VillageCareMAX Medicare Total Advantage*, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments.

Chapter 3. Using the plan's coverage for your medical and other covered services

You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, *VillageCareMAX Medicare Total Advantage* 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 *VillageCareMAX Medicare Total Advantage* or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is \$0, every month.

Your cost sharing will not change after being enrolled for 36 months in *VillageCareMAX Medicare Total Advantage*.

If prior to enrolling in *VillageCareMAX Medicare Total Advantage* you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in *VillageCareMAX Medicare Total Advantage* is \$0.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining *VillageCareMAX Medicare Total Advantage*, join *VillageCareMAX Medicare Total Advantage*, for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Chapter 3. Using the plan's coverage for your medical and other covered services

Similarly, if you made payments for 36 months while enrolled in *VillageCareMAX Medicare Total Advantage* and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1	Understanding covered services	56
Section 1.1	You pay nothing for your covered services.....	56
Section 1.2	What is the most you will pay for Medicare Part A and Part B covered medical services?.....	56
SECTION 2	Use the Medical <i>Benefits Chart</i> to find out what is covered for you and how much you will pay	57
Section 2.1	Your medical benefits and costs as a member of the plan	57
SECTION 3	What services are not covered outside of VillageCareMAX Medicare Total Advantage?	89
Section 3.1	Services <i>not</i> covered by VillageCareMAX Medicare Total Advantage	89
SECTION 4	What services are not covered by the plan?	90
Section 4.1	Services <i>not</i> covered by the plan (exclusions)	90

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding covered services

This chapter focuses on what services are covered and what you pay for these services. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of *VillageCareMAX Medicare Total Advantage*. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1	You pay nothing for your covered services
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Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care).

Section 1.2	What is the most you will pay for Medicare Part A and Part B covered medical services?
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Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of *VillageCareMAX Medicare Total Advantage*, the most you will have to pay out-of-pocket for Part A and Part B services in 2022 is \$6,700. The amounts you pay for covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount). If you reach the maximum out-of-pocket amount of \$6,700, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services *VillageCareMAX Medicare Total Advantage* covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk (*).

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including copayments, coinsurance and deductibles. Medicaid also covers services Medicare does not cover, like long-term care, over-the-counter drugs, home and community-based services, or other Medicaid-only services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2022* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)


- VillageCareMAX Medicare Total Advantage covers both Medicare and Medicaid benefits under one Plan. The below Benefits Chart in this chapter shows the list of Medicare-covered services. For a list of Medicaid-covered services and items, see Chapter 13 of this booklet.
- If you are within our plan's 3-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. During this period, we will also continue to provide all Medicaid benefits covered by the plan. However, we will not pay the Medicare premiums or cost sharing for which the state would be responsible for, if you had not lost your Medicaid coverage. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

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



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




Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for any covered treatments Covered for up to 50 visits per year (limit to 5 visits per month) for any covered acupuncture treatment when provided by a certified and licensed provider in the VillageCareMAX network. There is up to a \$80 limit per visit.	There is no copayment for up to 50 acupuncture visits per year.
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as:	There is no coinsurance, copayment, or deductible for acupuncture for chronic low back pain services.




Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Acupuncture for chronic low back pain * (continued)</p> <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p>Additional benefits covered by VillageCareMAX:</p> <p>You are also covered for an additional 50 visits per year to use for acupuncture for chronic low back pain and other covered acupuncture treatments. See “Acupuncture for any covered treatments” in this chart for more information.</p>	<p>*Prior Authorization required from VillageCareMAX for acupuncture for chronic low back pain.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services*</p> <ul style="list-style-type: none"> Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. 	<p>There is no coinsurance, copayment, or deductible for ambulance services.</p> <p>*Prior Authorization required from VillageCareMAX for non-emergency ambulance transportation.</p>
<p> Annual wellness visit</p> <p>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.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> One baseline mammogram between the ages of 35 and 39 One screening mammogram every 12 months for women age 40 and older Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>




Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Cardiac rehabilitation services*</p> <p>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. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered:</p> <ul style="list-style-type: none"> • Cardiac rehabilitation services, and • Intensive cardiac rehabilitation services <p>*Prior Authorization required from VillageCareMAX for Cardiac rehabilitation services.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
 Cervical and vaginal cancer screening (Continued) <ul style="list-style-type: none"> If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	preventive Pap and pelvic exams.
Chiropractic services* Covered services include: <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation. 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered chiropractic services.</p> <p>*Prior Authorization required from VillageCareMAX for Chiropractic services.</p>
 Colorectal cancer screening For people 50 and older, the following are covered: <ul style="list-style-type: none"> Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: <ul style="list-style-type: none"> Guaiaac-based fecal occult blood test (gFOBT) Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:	<p>There is no coinsurance, copayment, or deductible for dental services.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Dental services (Continued)*</p> <ul style="list-style-type: none"> Medicaid-covered dental services for preventive and essential care. See Chapter 13 for more information on Medicaid-covered services. <p>Additional Plan Benefits: You are covered for certain comprehensive dental services that are not covered by Medicare and Medicaid including:</p> <ul style="list-style-type: none"> Prosthodontics services (like crowns) limited to one every 60 months per tooth Endodontics (root canal) limited to 1 per lifetime per tooth 	<p>*Prior Authorization may be required from VillageCareMAX's dental vendor (Liberty Dental Plan).</p>
<p> Depression screening</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered services:</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
 Diabetes self-management training, diabetic services and supplies (Continued) custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. <ul style="list-style-type: none"> • Diabetes self-management training is covered under certain conditions. 	<ul style="list-style-type: none"> • Diabetes self-management training • Therapeutic shoes or inserts • Diabetic monitoring supplies
Durable medical equipment (DME) and related supplies* (For a definition of “durable medical equipment,” see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available in our Provider & Pharmacy Directory on our website at www.villagecaremax.org . The plan also covers Medicaid-covered DME and related supplies. See Chapter 13 for more information on Medicaid-covered services.	There is no coinsurance, copayment, or deductible for Medicare-covered durable medical equipment and supplies. *Prior Authorization required from VillageCareMAX for certain DME items.
Emergency care Emergency care refers to services that are: <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and 	There is no coinsurance, copayment, or deductible for emergency care. If you receive emergency care at an out-of-network

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Emergency care (continued)</p> <ul style="list-style-type: none"> • Needed to evaluate or stabilize an emergency medical condition. <p>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, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Additional benefits covered by VillageCareMAX:</p> <p>We cover Worldwide Emergency/Urgent Coverage and Emergency Transportation when you travel outside of the United States and its territories. See “Worldwide Emergency/Urgent Coverage” in this chart for details.</p>	<p>hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.</p>
<p> Health and wellness education programs</p> <p>You are covered for:</p> <ul style="list-style-type: none"> • Fitness membership through the Silver&Fit® Healthy Aging and Exercise program: <ul style="list-style-type: none"> ○ Access to fitness centers within the network ○ Home fitness kits if you prefer to work out at home • Educational materials, newsletter and resources that focus on health conditions such as high blood pressure, cholesterol, asthma, living with chronic conditions, heart attack, stroke prevention, back care, stress management, oral hygiene, weight management and special diets. 	<p>You pay nothing for covered:</p> <ul style="list-style-type: none"> • Fitness membership • Health and wellness education programs


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Hearing services*</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>The plan also covers Medicaid-covered Hearing services. See Chapter 13 for more information on Medicaid-covered services.</p>	<p>There is no coinsurance, copayment, or deductible for hearing services</p> <p>*Prior Authorization required from VillageCareMAX for hearing aids.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care*</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>You pay nothing for each Medicare-covered home health visit.</p> <p>*Prior Authorization required from VillageCareMAX for home health services.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Home Infusion Therapy*</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of the drugs or biologicals to an individual 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).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan or care. • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of the home infusion therapy and home infusion drugs furnished by qualified home infusion therapy supplier 	<p>There is no coinsurance, copayment, or deductible for Home infusion therapy.</p> <p>*Prior Authorization required from VillageCareMAX for home infusion therapy services.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p>	<p>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 <i>VillageCareMAX Medicare Total Advantage</i>.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Hospice care (continued)	
<p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:</p>	
<ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) 	
<p><u>For services that are covered by <i>VillageCareMAX Medicare Total Advantage</i> but are not covered by Medicare Part A or B:</u></p> <p><i>VillageCareMAX Medicare Total Advantage</i> will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p>	
<p><u>For drugs that may be covered by the plan's Part D benefit:</u></p>	
<p>Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>)</p>	
<p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	
<p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
 Immunizations	
<p>Covered Medicare Part B services include:</p>	
<ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary 	
<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B</p>	


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
 Immunizations (continued) <ul style="list-style-type: none"> • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>vaccines, and COVID-19 vaccines</p>
<p>Inpatient hospital care*</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>Plan covers unlimited additional days. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered inpatient hospital care.</p> <p>A "benefit period" begins the day you are admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you do not receive any inpatient hospital care or skilled nursing facility care 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.</p> <p>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.</p>
	<p>*Prior Authorization required from VillageCareMAX for</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <p>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 VillageCareMAX Medicare Total Advantage provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</p> <ul style="list-style-type: none"> • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	inpatient hospital care.
<p>Inpatient mental health care*</p> <ul style="list-style-type: none"> • Covered services include mental health care services that require a hospital stay. • You are covered for up to 190 days for inpatient services in a free-standing psychiatric hospital. • The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Additional days beyond the 190-day lifetime limit are covered through Medicaid. See Chapter 13 for more information. 	<p>There is no coinsurance, copayment, or deductible for covered inpatient mental health care.</p> <p>*Prior Authorization required from VillageCareMAX for inpatient mental health care.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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, 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 	<p>There is no coinsurance, copayment, or deductible for:</p> <ul style="list-style-type: none"> • Primary care provider and specialist visits • Diagnostic procedures and laboratory tests • Prosthetics and durable medical equipment • Medical and surgical supplies • Physical, speech & occupational therapy <p>*Prior authorization required from VillageCareMAX for certain services.</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
 Medical nutrition therapy (continued) physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
 Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) 	There is no coinsurance, copayment, or deductible for Medicare Part B prescription drugs *Prior authorization required from VillageCareMAX for certain injectable drugs.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs (Continued)</p> <ul style="list-style-type: none"> • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p> <p>Medicare Part B prescription drugs* (continued)</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services*</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • 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 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered opioid treatment program services.</p> <p>Prior Authorization required from VillageCareMAX for Opioid treatment program services.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered:</p> <ul style="list-style-type: none"> • X-rays • Diagnostic and therapeutic radiological services • Laboratory tests • Medical and surgical supplies <p>*Prior authorization required from VillageCareMAX for certain services.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered outpatient hospital observation.</p> <p>*Prior authorization required from VillageCareMAX for certain services.</p>

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation (Continued)	
Medicare – Ask!” This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
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.	There is no coinsurance, copayment, or deductible for Medicare-covered outpatient hospital services.
Covered services include, but are not limited to:	
<ul style="list-style-type: none">• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery• Laboratory and diagnostic tests billed by the hospital• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it• X-rays and other radiology services billed by the hospital• Medical supplies such as splints and casts• Certain drugs and biologicals that you can’t give yourself	*Prior authorization required from VillageCareMAX for certain services.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.	
You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or	
by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	

*Prior authorization required from VillageCareMAX for certain services.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient mental health care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. 	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered individual or group therapy session.</p>
<p>Outpatient rehabilitation services*</p> <ul style="list-style-type: none"> • 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) 	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered:</p> <ul style="list-style-type: none"> • Physical Therapy visits • Occupational Therapy visits • Speech Language Therapy visits <p>*Prior authorization required from VillageCareMAX.</p>
<p>Outpatient substance abuse services*</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Individual and group sessions for counseling or therapy • Treatment of inappropriate alcohol and drug use • Family counseling as needed to help with treatment <p>Substance abuse program services that provide individualized plan of care with interventions to reduce/eliminate the use of alcohol and/or other substances</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered individual and group therapy session.</p> <p>*Prior Authorization required from VillageCareMAX for outpatient substance abuse services.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered:</p> <ul style="list-style-type: none"> • Ambulatory Surgical Center visit • Outpatient Hospital services <p>*Prior Authorization required from VillageCareMAX for visits certain services.</p>
<p>Over-the-Counter (OTC) Health-Related & Grocery Items</p> <p>As a member of VillageCareMAX Medicare Total Advantage, you receive an Over-the-Counter (OTC) card with a monthly amount for plan approved items:</p> <ul style="list-style-type: none"> • Covered for up to \$2,700 per year (\$225 per month) to buy nonprescription drugs, health-related and grocery items at participating locations • Any unused balance will expire at the end of each month and will not carry over to the next month or year • You can only use the OTC card to purchase items for yourself. You cannot use the OTC card to buy items for family members or friends. • The OTC card is not a debit or credit and cannot be converted to cash • Some items are labeled “Dual Purpose” and can only be purchased if recommended by your doctor • Some OTC items may be available to you through Medicaid when you use your Medicaid ID card <p>Grocery Items (Healthy Foods)</p> <p>Grocery items are a part of Special Supplemental Benefits for the Chronically Ill (SSCBI) and not all members may qualify. Generally members enrolled in VillageCareMAX Medicare Total Advantage will qualify. See “Special Supplemental</p>	<p>You pay nothing for covered OTC products and grocery items up to \$2,700 per year (\$225 per month)</p> <p>You can visit our website at www.villagecaremax.org or contact Member Services for a comprehensive listing of approved items and more details about how to activate and use your OTC card.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Over-the-Counter (OTC) Health-Related & Grocery Items (continued)</p> <p>Benefits for the Chronically Ill” in this chart for more information.</p>	
<p>Partial hospitalization services*</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered Partial hospitalization services.</p> <p>*Prior Authorization required from VillageCareMAX for partial hospitalization services.</p>
<p>Physician Call Line</p> <p>You are covered for 24-hour access per day to speak to a doctor about your non-emergency health related concerns.</p> <p>You can reach the Physician Call Line at 1-844-484-7362 (TTY: 711).</p> <p>Note: If you have a medical emergency, please call 911 immediately.</p>	<p>You pay nothing for Physician Call Line services</p>
<p>Physician/Practitioner services, including doctor’s office visits*</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location Consultation, diagnosis, and treatment by a specialist Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment 	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered Primary Care Provider (PCP) or Specialist visit.</p> <p>*Prior Authorization required from VillageCareMAX for certain non-routine procedures.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)



Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits* (continued)	
<ul style="list-style-type: none"> • Certain telehealth services, including: Skilled Nursing Facility (SNF), Partial Hospitalization, Home Health Services, Glaucoma Screening, Diabetes Self-Management Training, Cardiac Rehabilitation Services, Intensive Cardiac Rehabilitation Services, Pulmonary Rehabilitation Services, SET for PAD Services, Individual and Group Sessions for Mental Health Specialty Services, Kidney Diseases Education Services, Eye Exams, Hearing Exams, Emergency/Post-Stabilization Services, Primary Care Physician Services, Other Health Care Professional, Individual and Group Sessions for Psychiatric Services, Physical Therapy and Speech-Language Pathology Services, Opioid Treatment Program Services, Outpatient Hospital Services, Observation Services, Observation Services, and Individual and Group Sessions for Outpatient Substance Abuse. Contact the plan for more information. <ul style="list-style-type: none"> ○ 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. ○ Telehealth services can be offered through any available means of electronic exchange that complies with guidelines • 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 a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and 	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits* (continued)</p> <ul style="list-style-type: none"> ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and following and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ 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 other doctors by phone, internet, or electronic health record if you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease or services that would be covered when provided by a physician) 	
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 <p>The plan also covers Medicaid-covered podiatry services. See Chapter 13 for more information on Medicaid-covered services.</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered visit for podiatry services.</p> <p>Medicare-covered podiatry services are for medically necessary foot care.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)


Services that are covered for you	What you must pay when you get these services
 Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.	There is no coinsurance, copayment, or deductible for each Medicare-covered: <ul style="list-style-type: none"> • Prosthetic devices • Medical supplies *Prior Authorization required from VillageCareMAX for prosthetic devices and medical supplies.
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.	There is no coinsurance, copayment, or deductible for each Medicare-covered pulmonary rehabilitation services. *Prior Authorization required from VillageCareMAX
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse (Continued)	
<p>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.</p>	
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written 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 subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (Continued)</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."</p>	<p>There is no coinsurance or copayment for Medicare-covered services to treat kidney disease and conditions.</p> <p>Notification to VillageCareMAX about dialysis services is preferred.</p>
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.")</p> <p>You are covered for up to 100 days each benefit period. The plan also provides additional coverage for Medicaid-covered services.</p>	<p>There is no coinsurance, copayment, or deductible for covered skilled nursing facility care.</p> <p>*Prior Authorization required from</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>There is no prior hospital stay required. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other 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 <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital 	<p>VillageCareMAX for skilled nursing facility services.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (Continued)</p> <p>you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>cessation preventive benefits.</p>
<p>Special Supplemental Benefits for the Chronically Ill Grocery Items (Healthy Foods)</p> <p>As a member of VillageCareMAX Medicare Total Advantage, you receive an Over-the-Counter (OTC) card with a monthly amount for plan approved items:</p> <ul style="list-style-type: none"> • Covered for up to \$2,700 per year (\$225 per month) to buy grocery items at participating locations • Any unused balance will expire at the end of each month and will not carry over to the next month or year • You can only use the OTC card to purchase items for yourself. You cannot use the OTC card to buy items for family members or friends. • The OTC card is not a debit or credit and cannot be converted to cash <p>Generally, members that meet the eligibility requirements to enroll in VillageCareMAX Medicare Total Advantage are eligible for special supplemental benefits for the chronically ill. The plan covers grocery items for members that continue to meet the following criteria:</p> <ul style="list-style-type: none"> • Have one or more comorbid and complex chronic conditions, require intense care coordination, at a high risk for hospitalization or other adverse health outcomes, and get care management services. • The chronic conditions include: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; 	<p>You pay nothing for covered grocery items up to \$2,700 per year (\$225 per month)</p> <p>You can visit our website at www.villagecaremax.org or contact Member Services for a comprehensive listing of approved items and more details about how to activate and use your OTC card.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Special Supplemental Benefits for the Chronically Ill</p> <p>Grocery Items (Healthy Foods) (Continued)</p> <p>Dementia; Diabetes; End-stage liver disease; Endstage renal disease (ESRD); Severe hematologic disorders;</p> <ul style="list-style-type: none"> HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke, and long term care needs. 	
<p>Supervised Exercise Therapy (SET)*</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD).</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication Be conducted in a hospital outpatient setting or a physician's office Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered Supervised Exercise Therapy (SET).</p> <p>*Prior authorization is required from VillageCareMAX for SET.</p>
<p>Transportation services (non-emergency) *</p> <p>Plan covers non-emergency transportation services that are not covered by Medicare:</p> <ul style="list-style-type: none"> Medicaid-covered unlimited transportation trips for health-related activities. See Chapter 13 for more information on Medicaid-covered services. 	<p>You pay nothing for Medicaid-covered transportation trips.</p> <p>* Prior authorization required from VillageCareMAX at least 2 days in advance.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Additional benefits covered by VillageCareMAX:</p> <p>We cover Worldwide Emergency/Urgent Coverage and Emergency Transportation when you travel outside of the United States and its territories. See “Worldwide Emergency/Urgent Coverage” in this chart for details.</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered urgently needed services.</p>
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, and 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 two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered vision services.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Vision care (continued)</p> <p>Additional Plan Benefits:</p> <p>Plan covers additional vision benefits that are not covered by Medicare:</p> <ul style="list-style-type: none"> • One (1) routine eye exam every year • Up to \$350 every year for contact lenses or eyeglasses (lenses and frames) <p>The plan also covers Medicaid-covered vision services. See Chapter 13 for more information on Medicaid-covered services.</p>	<p>You pay nothing for routine eye exam and eyewear.</p> <p>*Prior authorization may be required.</p>
<p> “Welcome to Medicare” preventive visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>
<p>Worldwide Emergency/Urgent Care Coverage</p> <p>You are covered for up to \$50,000 per year for Worldwide Emergency/Urgent Coverage and Emergency Transportation when you travel outside of the United States and its territories.</p> <p>Worldwide coverage is for emergency or urgently needed care only. VillageCareMAX does not pay providers outside of the United States and its territories directly. You will need to pay the bill yourself when you get care. Then you can submit a request for the plan to pay you back.</p>	<p>There is no coinsurance, copayment, or deductible for Worldwide Emergency/Urgent Care Coverage and Emergency Transportation.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Worldwide Emergency/Urgent Care Coverage (continued)	
The following information is required for all requests to pay for worldwide coverage:	
<ul style="list-style-type: none"> • Itemized bills (should include date of service, services received, and cost of each item) • Medical records (copies of original medical reports, admission notes, emergency room records, and/or consultation reports) • Proof of payment (receipts or bank or credit card statements) • Proof of travel (copy of itinerary and/or airline tickets) 	
The plan will review all documents and can request additional information as needed before making a decision to approve or deny the request for payment. Contact the plan for more information.	

SECTION 3 What services are covered outside of VillageCareMAX Medicare Total Advantage?

Section 3.1	Services <i>not</i> covered by VillageCareMAX Medicare Total Advantage
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The following services are not covered by *VillageCareMAX Medicare Total Advantage* but are available through Medicare.

- **Hospice services related to your terminal prognosis:** original Medicare (rather than our plan) will pay for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

See Chapter 13 for information on services that are available through Medicaid but not covered by VillageCareMAX Medicare Total Advantage.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**SECTION 4 What services are not covered by the plan?****Section 4.1 Services *not* covered by the plan (exclusions)**

This section tells you what services are “excluded” by Medicare. Excluded means that the plan doesn’t cover these services. In some cases, Medicaid covers items or services that are excluded by the plan and Medicare. For more information about Medicaid-covered benefits, see Chapter 13 or call Member Services (phone numbers are printed on the back cover of this booklet).

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

We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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 6.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital		✓ Covered only when medically necessary
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	✓	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home		<p>✓</p> <p>The plan covers Medicaid-covered Private Duty Nursing when medically necessary.</p> <p>(See Chapter 13 for more information)</p>
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care		<p>✓</p> <p>The plan covers Medicaid-covered custodial care when medically necessary.</p> <p>(See Chapter 13 for more information).</p>
Homemaker services include basic household assistance, including light housekeeping or light meal preparation		<p>✓</p> <p>The plan covers Medicaid-covered homemaker services when medically necessary.</p> <p>(See Chapter 13 for more information).</p>
Fees charged for care by your immediate relatives or members of your household		<p>✓</p> <p>The plan covers Medicaid-covered Consumer Directed Personal Assistance Services (CDPAS) when medically necessary.</p> <p>(See Chapter 13 for more information).</p>
Cosmetic surgery or procedures		<p>✓</p> <ul style="list-style-type: none"> 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

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		to produce a symmetrical appearance
Routine dental care, such as cleanings, fillings or dentures		<p>✓</p> <p>The plan covers Medicaid-covered routine dental care.</p> <p>(See Chapter 13 for more information).</p>
Non-routine dental care		<p>✓</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p> <p>The plan also covers:</p> <ul style="list-style-type: none"> • Certain comprehensive dental services that are not covered by Medicare or Medicaid • Medicaid-covered non-routine dental care. (See Chapter 13 for more information).
Routine chiropractic care		<p>✓</p> <p>Manual manipulation of the spine to correct a subluxation is covered.</p>
Routine foot care		<p>✓</p> <p>Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.</p> <p>The plan also covers Medicaid-covered routine foot care. (See Chapter 13 for more information).</p>
Home-delivered meals		<p>✓</p> <p>The plan covers Medicaid-covered Home-delivered meals.</p> <p>(See Chapter 13 for more information).</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes		<p>✓</p> <p>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</p> <p>The plan also covers Medicaid-covered orthopedic shoes when medically necessary. (See Chapter 13 for more information).</p>
Supportive devices for the feet		<p>✓</p> <p>Orthopedic or therapeutic shoes for people with diabetic foot disease.</p> <p>The plan also covers Medicaid-covered supportive devices for the feet when medically necessary. (See Chapter 13 for more information)</p>
Routine hearing exams, hearing aids, or exams to fit hearing aids.		<p>✓</p> <p>The plan covers Medicaid-covered hearing services and hearing aids when medically necessary.</p> <p>(See Chapter 13 for more information).</p>
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids		<p>✓</p> <p>Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.</p> <p>The plan also covers:</p> <ul style="list-style-type: none"> • Annual eye exam and up to \$350 per year for eye wear • Medicaid-covered vision services and eyewear when medically necessary. (See

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Chapter 13 for more information).
Reversal of sterilization procedures and or non-prescription contraceptive supplies	✓	
Naturopath services (uses natural or alternative treatments)	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

*Using the plan's coverage for your
Part D prescription drugs*

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Chapter 5. Using the plan's coverage for your Part D prescription drugs

SECTION 1	Introduction	98
Section 1.1	This chapter describes your coverage for Part D drugs.....	98
Section 1.2	Basic rules for the plan's Part D drug coverage.....	99
SECTION 2	Fill your prescription at a network pharmacy or through the plan's mail-order service.....	99
Section 2.1	To have your prescription covered, use a network pharmacy	99
Section 2.2	Finding network pharmacies	99
Section 2.3	Using the plan's mail-order services	100
Section 2.4	How can you get a long-term supply of drugs?.....	101
Section 2.5	When can you use a pharmacy that is not in the plan's network?.....	102
SECTION 3	Your drugs need to be on the plan's "Drug List"	103
Section 3.1	The "Drug List" tells which Part D drugs are covered.....	103
Section 3.2	There are two (2) "cost-sharing tiers" for drugs on the Drug List	104
Section 3.3	How can you find out if a specific drug is on the Drug List?	104
SECTION 4	There are restrictions on coverage for some drugs.....	105
Section 4.1	Why do some drugs have restrictions?.....	105
Section 4.2	What kinds of restrictions?.....	105
Section 4.3	Do any of these restrictions apply to your drugs?	106
SECTION 5	What if one of your drugs is not covered in the way you'd like it to be covered?	106
Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered	106
Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?	107
SECTION 6	What if your coverage changes for one of your drugs?	109
Section 6.1	The Drug List can change during the year	109
Section 6.2	What happens if coverage changes for a drug you are taking?	109
SECTION 7	What types of drugs are <i>not</i> covered by the plan?	111
Section 7.1	Types of drugs we do not cover	111
SECTION 8	Show your plan membership card when you fill a prescription. 112	

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Section 8.1	Show your membership card	112
Section 8.2	What if you don't have your membership card with you?	112
SECTION 9	Part D drug coverage in special situations	112
Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?	112
Section 9.2	What if you're a resident in a long-term care (LTC) facility?	113
Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?	113
Section 9.4	What if you're in Medicare-certified hospice?	114
SECTION 10	Programs on drug safety and managing medications	114
Section 10.1	Programs to help members use drugs safely	114
Section 10.2	Drug Management Program (DMP) to help members safely use their opioid medications	115
Section 10.3	Medication Therapy Management (MTM) program to help members manage their medications	116
SECTION 11	We send you reports that explain payments for your drugs and which payment stage you are in	117
Section 11.1	We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")	117
Section 11.2	Help us keep our information about your drug payments up to date	117

Chapter 5. Using the plan's coverage for your Part D prescription drugs**How can you get information about your drug costs?**

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does 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, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1	This chapter describes your coverage for Part D drugs
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This chapter **explains rules for using your coverage for Part D drugs.**

In addition to your coverage for Part D drugs, *VillageCareMAX Medicare Total Advantage* also covers some drugs under the plan’s medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 (*What if you’re in Medicare-certified hospice*). For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

The following sections discuss coverage of your drugs under the plan’s Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. For more information about your Medicaid drug coverage, contact the New York State Medicaid Pharmacy clinical call center at 1-877-309-9493 or visit the website at www.health.ny.gov/health_care/medicaid/program/pharmacy.htm.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Section 1.2 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

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

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

Section 2.2 Finding network pharmacies**How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your *Provider and Pharmacy Directory*, visit our website (www.villagecaremax.org), or call Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 5. Using the plan's coverage for your Part D prescription drugs

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Provider and Pharmacy Directory*. You can also find information on our website at www.villagecaremax.org.

What if you need a specialized pharmacy?

Sometimes 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, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3	Using the plan's mail-order services
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For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked as "NM" (Non-Mail order drug) in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

To get information about filling your prescriptions by mail, please review the mail order brochure included in your Welcome Packet sent in the mail. You can also call the mail order delivery program at 1-855-873-8739 (TTY: 711) or visit www.medimpactdirect.com.

Usually a mail-order pharmacy order will get to you in no more than 14 days from the date the order is placed. If there is a delay in the receipt of your mail order prescription, you can get a retail 30-day supply of your prescribed medication. Please call our pharmacy vendor at 1-888-807-6806 if the delivery of your mail order prescription has been delayed.

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

After the pharmacy receives 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. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail order prescriptions. For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by phone or email. You can update your contact information at any time by calling the mail order delivery program at 1-855-873-8739 (TTY: 711).

Section 2.4	How can you get a long-term supply of drugs?
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The plan offers two ways to get a long-term supply (also called an “extended supply”) of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan’s network **mail-order services**. The drugs that are not available through the plan’s mail-order service are marked as “NM” (Non-Mail order drug) in our Drug List. Our plan’s mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You cannot obtain a covered drug in a timely manner within the plan's service area because there is no network pharmacy available within a reasonable driving distance.
- A drug has been dispensed by an out-of-network institution-based pharmacy while you are in the emergency room.
- You become ill or run out of medications and cannot access a network pharmacy while out of the service area
- Filling a prescription for a covered drug and that drug is not regularly stocked at an accessible network pharmacy
- During any federal disaster or other public health emergency in which you are evacuated or displaced from your residence and cannot obtain covered Part D drugs at a network pharmacy

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. For more information about your Medicaid drug coverage, contact the New York State Medicaid Pharmacy clinical call center at 1-877-309-9493 or visit the website at www.health.ny.gov/health_care/medicaid/program/pharmacy.htm.

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

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 5. Using the plan's coverage for your Part D prescription drugs

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

The Drug List does not include drugs that are covered by Medicaid. For more information about your Medicaid drug coverage, please contact the New York State Medicaid Program (You can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6).

Section 3.2	There are two (2) “cost-sharing tiers” for drugs on the Drug List
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Every drug on the plan's Drug List is in one of two (2) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-Sharing Tier 1 includes generic drugs and is the lowest cost-sharing tier
- Cost-Sharing Tier 2 includes brand drugs and is the highest cost-sharing tier.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3	How can you find out if a specific drug is on the Drug List?
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You have *three* ways to find out:

1. Check the most recent Drug List we provided electronically
2. Visit the plan's website (www.villagecaremax.org). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Chapter 5. Using the plan's coverage for your Part D prescription drugs

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug).

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes the requirement for

Chapter 5. Using the plan's coverage for your Part D prescription drugs

getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

Section 4.3	Do any of these restrictions apply to your drugs?
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The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (www.villagecaremax.org).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

SECTION 5	What if one of your drugs is not covered in the way you'd like it to be covered?
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Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered
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We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you

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

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

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of

Chapter 5. Using the plan's coverage for your Part D prescription drugs

a 30-day supply. If your prescription is written for fewer days, we will 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. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.

- **For current members with level of care changes:**

VillageCareMAX Medicare Total Advantage has a transition policy which ensures that continued drug coverage is provided to new and current members. There are times when you may experience a change in your level of care, such as admission to a long-term care facility or hospital (or discharge from these settings). In these cases, we will provide you with a one-time emergency supply of a non-formulary medication. Non-formulary drugs include both drugs that are not on the plan's formulary and drugs that are on our formulary but require prior authorization or step therapy under the plan's utilization management rules.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services 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. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

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

Chapter 5. Using the plan's coverage for your Part D prescription drugs

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?**Information on changes to drug coverage**

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
 - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will

Chapter 5. Using the plan's coverage for your Part D prescription drugs

appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both.

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
 - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
 - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
 - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
 - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
 - **Other changes to drugs on the Drug List**
 - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug or both.
 - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
 - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List

Chapter 5. Using the plan's coverage for your Part D prescription drugs

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

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

Section 7.1	Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

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

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

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. You can contact the New York State Medicaid program to find out which excluded drugs are covered under your Medicaid benefit.

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

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for your covered prescription drug.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. You must show your Medicaid card to fill prescriptions for drugs covered under Medicaid.

Section 8.2 What if you don't have your membership card with you?

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then ask us to reimburse you). See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

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

Chapter 5. Using the plan's coverage for your Part D prescription drugs

our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

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

Check your *Provider & Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Special note about 'creditable coverage':

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

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

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4	What if you're in Medicare-certified hospice?
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Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1	Programs to help members use drugs safely
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical 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 written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

Section 10.2	Drug Management Program (DMP) to help members safely use their opioid medications
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We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

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

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

The DMP may not apply to you if you have certain medical conditions, such as cancer or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3	Medication Therapy Management (MTM) program to help members manage their medications
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We have a program that can help our members with complex health needs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take 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 of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

Section 11.1	We send you a monthly summary called the “Part D Explanation of Benefits” (the “Part D EOB”)
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Our plan keeps track of the costs of your prescription drugs. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

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

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

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

Section 11.2	Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to

Chapter 5. Using the plan's coverage for your Part D prescription drugs

keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

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

CHAPTER 6

What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs**How can you get information about your drug costs?**

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We have 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, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back cover of this booklet.)

CHAPTER 7

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

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

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SECTION 1	Situations in which you should ask us to pay for your covered services or drugs.....	123
Section 1.1	If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment	123
SECTION 2	How to ask us to pay you back or to pay a bill you have received	125
Section 2.1	How and where to send us your request for payment	125
SECTION 3	We will consider your request for payment and say yes or no ..	126
Section 3.1	We check to see whether we should cover the service or drug	126
Section 3.2	If we tell you that we will not pay for the medical care or drug, you can make an appeal	127
SECTION 4	Other situations in which you should save your receipts and send copies to us	127
Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs.....	127

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

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

Section 1.1	If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment
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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid for the service, we will pay you back.

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

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive 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. You will need to submit paperwork for us to handle the reimbursement. Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.) Save your receipt and send a copy to us when you ask us to pay you back.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

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

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

7. When you pay the cost for Worldwide Emergency/Urgent Coverage when you travel outside of the United States and its Territories

You are covered for up to \$50,000 per year for Worldwide Emergency/Urgent Coverage when you travel outside of the United States and its territories. If you get emergency or urgently needed care outside of the United States and its territories, you will pay the bill, and then submit a request for the plan to pay you back.

The following information is required for all requests to pay for worldwide coverage:

- Itemized bills (should include date of service, services received, and cost of each item)
- Medical records (copies of original medical reports, admission notes, emergency room records, and/or consultation reports)
- Proof of payment (receipts or bank or credit card statements)
- Proof of travel (copy of itinerary and/or airline tickets)

The plan will review all documents and can request additional information as needed before making a decision to approve or deny the request for payment. You can call Member Services for more information (phone numbers are printed on the back cover of this booklet).

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with 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.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don’t have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.villagecaremax.org) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

Mail your request for payment for **Part C claims (medical costs)** together with any bills or paid receipts to us at this address:

ILS – VillageCare
P.O. Box 21516
Eagan, MN 55121

Mail your request for payment for **Part D claims (prescription drug costs)** together with any bills or receipts to us at this address:

MedImpact Healthcare Systems, Inc.
P.O. Box 509108
San Diego, CA 92150-9010

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called “Where to send a request asking us to pay for medical care or a drug you have received.”

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1	We check to see whether we should cover the service or drug
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

Section 3.2 If we tell you that we will not pay for the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 9. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 5, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

Chapter 8. Your rights and responsibilities

SECTION 1	Our plan must honor your rights as a member of the plan	131
Section 1.1	We must provide information in a way that works for you (in languages other than English, in braille, in large print, in audio, or other alternate formats, etc.).....	131
Section 1.2	We must ensure that you get timely access to your covered services and drugs	132
Section 1.3	We must protect the privacy of your personal health information.....	133
Section 1.4	We must give you information about the plan, its network of providers, and your covered services	134
Section 1.5	We must support your right to make decisions about your care	135
Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made	137
Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?	137
Section 1.8	How to get more information about your rights.....	138
SECTION 2	You have some responsibilities as a member of the plan	138
Section 2.1	What are your responsibilities?	138

Chapter 8. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1	We must provide information in a way that works for you (in languages other than English, in braille, in large print, in audio, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can provide written materials in Spanish and Chinese. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with VillageCareMAX Grievances Department at 1-800-469-6292 (TTY: 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact VillageCareMAX Member Services for additional information.

Para recibir información nuestra de una manera que funcione para usted, llame a Servicios para Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de traducción disponibles para responder preguntas de miembros con alguna discapacidad o que no hablan inglés. Podemos proporcionar materiales escritos en español y en chino. También podemos darle información en braille, en letra grande, o en otros formatos alternativos, sin costo, si lo necesita. Estamos obligados a darle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información de nosotros de una manera que funcione para usted, por favor llame a Servicios para Miembros (los números telefónicos están impresos en la parte posterior de este folleto).

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar un reclamo con el Departamento de Quejas de VillageCareMAX al 1-800-469-6292 (TTY: 711). También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina de Derechos Civiles. La información de contacto está incluida en esta Evidencia de cobertura o con

Chapter 8. Your rights and responsibilities

este envío por correo postal, o puede comunicarse con Servicios para Miembros de VillageCareMAX para obtener información adicional.

如需我們以適合您的方式提供資訊，請致電會員服務部（電話號碼印在本手冊封底）。

我們的計劃配有專員及免費的翻譯服務，以回答不說英語的會員提出的問題。我們可以提供西班牙語和中文版的書面材料。我們也可以盲文、大號字體印刷版或您需要的其他可選形式向您提供資訊。若您因殘障而符合享有 Medicare 的條件，我們需向您提供您可獲得及適合您的計劃福利的相關資訊。如需我們以適合您的方式提供資訊，請致電會員服務部（電話號碼印在本手冊封底）。

如果您因語言或殘障問題而在獲取計劃提供的資訊方面遇到任何困難，請致電 1-800-MEDICARE (1-800-633-4227) 聯絡 Medicare（全天候服務），並說明您要提出投訴。聽障和語障人士可致電 1-877-486-2048。

Section 1.2	We must ensure that you get timely access to your covered services and drugs
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As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network or out-of-network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). We do not require you to get referrals.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 5 tells what you can do.)

Chapter 8. Your rights and responsibilities

Section 1.3	We must protect the privacy of your personal health information
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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.
- The laws that protect your privacy give you rights related to getting 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.
- In most situations, if we 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 first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 8. Your rights and responsibilities

Section 1.4	We must give you information about the plan, its network of providers, and your covered services
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As a member of *VillageCareMAX Medicare Total Advantage*, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in Braille, large print, audio or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at www.villagecaremax.org.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

Chapter 8. Your rights and responsibilities

- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.5	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

Chapter 8. Your rights and responsibilities

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the New York State Department of Health by contacting them at the below address and phone number:

The New York State Department of Health
Office of the Commissioner
Empire State Plaza Corning Tower
Albany, NY 12237

Telephone Number: 1-800-541-2831

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).

Chapter 8. Your rights and responsibilities

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2	You have some responsibilities as a member of the plan
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Section 2.1	What are your responsibilities?
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Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

Chapter 8. Your rights and responsibilities

- We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most *VillageCareMAX Medicare Total Advantage* members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
 - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.

Chapter 8. Your rights and responsibilities

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
 - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
 - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9

*What to do if you have a problem
or complaint (coverage decisions,
appeals, complaints)*

Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)

Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)

BACKGROUND...	145
SECTION 1 Introduction	145
Section 1.1 What to do if you have a problem or concern	145
Section 1.2 What about the legal terms?	145
SECTION 2 You can get help from government organizations that are not connected with us	146
Section 2.1 Where to get more information and personalized assistance	146
SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan	147
SECTION 4 Problems with your benefits	147
Section 4.1 Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?	147
SECTION 5 A guide to the basics of coverage decisions and appeals	148
Section 5.1 Asking for coverage decisions and making appeals: the big picture	148
Section 5.2 How to get help when you are asking for a coverage decision or making an appeal	149
Section 5.3 Which section of this chapter gives the details for your situation?	150
SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal	151
Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care	151
Section 6.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)	152
Section 6.3 Step-by-step: How to make a Level 1 Appeal (How to ask for a review of a medical care coverage decision made by our plan)	156
Section 6.4 Step-by-step: How a Level 2 Appeal is done	159
Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?	161
SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal	163

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug	163
Section 7.2	What is an exception?.....	165
Section 7.3	Important things to know about asking for exceptions	165
Section 7.4	Step-by-step: How to ask for a coverage decision, including an exception	166
Section 7.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)	169
Section 7.6	Step-by-step: How to make a Level 2 Appeal.....	172
SECTION 8	How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.....	174
Section 8.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights	175
Section 8.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	176
Section 8.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date	178
Section 8.4	What if you miss the deadline for making your Level 1 Appeal?.....	180
SECTION 9	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	182
Section 9.1	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services	182
Section 9.2	We will tell you in advance when your coverage will be ending.....	183
Section 9.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	184
Section 9.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	186
Section 9.5	What if you miss the deadline for making your Level 1 Appeal?.....	187
SECTION 10	Taking your appeal to Level 3 and beyond	190
Section 10.1	Levels of Appeal 3, and 4, for Medical Service Appeals	190
Section 10.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals	190
SECTION 11	How to make a complaint about quality of care, waiting times, customer service, or other concerns.....	192
Section 11.1	What kinds of problems are handled by the complaint process?	192
Section 11.2	The formal name for “making a complaint” is “filing a grievance”	194
Section 11.3	Step-by-step: Making a complaint	194

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Section 11.4	You can also make complaints about quality of care to the Quality Improvement Organization.....	195
Section 11.5	You can also tell Medicare about your complaint.....	196

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****BACKGROUND****SECTION 1 Introduction****Section 1.1 What to do if you have a problem or concern**

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

These processes have been approved by Medicare and Medicaid. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “integrated organization determination” or “coverage determination,” or “at risk determination.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**SECTION 2 You can get help from government organizations that
are not connected with us**

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<https://www.medicare.gov>).

You can get help and information from Medicaid

The State of New York has created an ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide members free, confidential assistance on any services offered by VillageCareMAX Medicare Total Advantage Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

For more information and help in handling a problem with your Medicaid benefits, you can contact the New York State Medicaid program:

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Method	New York City Human Resources Administration/Department of Social Services (HRA/DSS) – Contact Information
CALL	1-888-692-6116 Available 8:00 am to 8:00 pm, Monday through Friday
WRITE	785 Atlantic Avenue Brooklyn, NY 11238
WEBSITE	www.nyc.gov/hra

SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan

You have Medicare and get assistance from Medicaid. Information in this chapter applies to all of your Medicare and Medicaid benefits. For most of your benefits, you will use one process for your Medicare benefits and your Medicaid benefits. This is sometimes called an “integrated process” because it integrates Medicare and Medicaid processes.

SECTION 4 Problems with your benefits

Section 4.1 Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare or Medicaid** benefits, use this chart:

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1	Asking for coverage decisions and making appeals: the big picture
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The process for asking for coverage decisions and appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare or Medicaid for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won’t review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn’t legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) See Section 6.4 of this chapter for more information about Level 2 Appeals.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 5.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other health care provider can make a request for you.**
 - For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
 - If your doctor or other prescriber asks that a service or item you are already getting be continued during your appeal, you may need to appoint your doctor or other prescriber as your representative.
 - To request any appeal after Level 2, your doctor must be appointed as your representative.
 - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other health care provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.villagecaremax.org). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3	Which section of this chapter gives the details for your situation?
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There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal



Have you read Section 5 of this chapter (“(A guide to “the basics” of coverage decisions and appeals)?”) If not, you may want to read it before you start this section.

Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.our plan covers this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical healthmedica lcare provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting (that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Chapter 9, Section 8: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 9, Section 9: *How to ask us to keep covering home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

Which of these situations are you in?If:	You can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 6.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 6.3 of this chapter.
Have we told you we will be stopping or reducing a medical service you are already getting?	You may be able to keep those services or items during your appeal Skip ahead to Section 6.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 6.5 of this chapter.

Section 6.2

Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms

When a coverage decision involves your medical care, it is called an “**integrated organization determination**.”

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

Legal Terms
A “fast coverage decision” is called an “integrated expedited determination.”

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, “*How to contact us when you are asking for a coverage decision about your medical care.*”

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an **answer within 72 hours** after we receive your request.

- For a request for a **medical item or service**, we **can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
 - **For a request for a medical item or service**, we **can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.***Deadlines for a “fast” coverage decision***

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written statement that explains why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
 - For a request for a medical item or service, we can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
 - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 6.3 Step-by-step: How to make a Level 1 Appeal
(How to ask for a review of a medical care coverage decision
made by our plan)****Legal Terms**

An appeal to the plan about a medical care coverage decision is called a plan “**integrated reconsideration.**”

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, “*How to contact us when you are making an appeal about your medical care.*”
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. If your doctor or other prescriber is asking that a service or item you are already getting be continued during your appeal, you may need to give your doctor or other prescriber your permission as your representative to act on your behalf. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at www.villagecaremax.org. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a 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 for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a free copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms
A “fast appeal” is also called an “integrated expedited reconsideration.”

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service, item, or drug that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 Appeal. We will continue covering the service, item, or drug if you ask for a Level 1 Appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you meet this deadline, you can keep getting the service, item, or drug with no changes while your appeal is pending. You will also keep getting all other services, items, or drugs (that are not the subject of your appeal) with no changes.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - If you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Office of Administrative Hearings for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service within **30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - If you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

medical item or service. If we decide we need to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process. Then an independent outside organization will review it. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the independent review organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to an independent review organization, called the “Office of Administrative Hearings.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 6.4	Step-by-step: How a Level 2 Appeal is done
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If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Office of Administrative Hearings** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Step 1: The Office of Administrative Hearings reviews your appeal.

- **The Office of Administrative Hearings is an independent New York State agency.** It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **We will send you a free copy of your case file.**

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- You have a right to give the Office of Administrative Hearings additional information to support your appeal.
- Reviewers at the Office of Administrative Hearings will take a careful look at all of the information related to your appeal. The Office of Administrative Hearings of Administrative Hearings will contact you to schedule a hearing.

If you had a “fast” appeal at Level 1, you may automatically have a “fast” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you may automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal. In some cases, if you had a fast appeal to our plan at Level 1 you will not automatically receive a fast appeal at Level 2. You will get a fast appeal if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- If your request is for a medical item or service and the Office of Administrative Hearings needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Office of Administrative Hearings can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2.
 - If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **about 60 calendar days** of when it receives your appeal.
 - If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- If your request is for a medical item or service and the Office of Administrative Hearings needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Office of Administrative Hearings can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 288 for information about continuing your benefits during Level 1 Appeals.

Step 2: The Office of Administrative Hearings gives you their answer.

The Office of Administrative Hearings will tell you its decision in writing and explain the reasons for it.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If the Office of Administrative Hearings says yes to part or all of a request for a medical item or service, we must:**
 - authorize the medical care coverage **within 72 hours** or
 - provide the service **within 14 calendar days** after we receive the Hearing Office's decision for **standard requests** or
 - provide the service **within 72 hours** from the date the plan receives the Hearing Office's decision for **expedited requests**.
- **If the Office of Administrative Hearings says yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Part B prescription drug under dispute:**
 - **within 72 hours** after we receive the Hearing Office's decision for **standard requests** or
 - **within 24 hours** from the date we receive the Hearing Office's decision for **expedited requests**.
- **If this organization says no to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")**
 - If the Office of Administrative Hearings "upholds the decision" you have the right to a Level 3 Appeal.

Step 3: Choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you get after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. Section 10 in this chapter tells more about Levels 3, and 4 of the appeals process.

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 30 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Office of Administrative Hearings reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days.
- If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal**

Have you read Section 5 of this chapter (“(A guide to “the basics” of coverage decisions and appeals)?”) If not, you may want to read it before you start this section.

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s *List of Covered Drugs (Formulary)*. To be covered, the 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 Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **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.
- For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary) *List of Covered Drugs (Formulary)* Drug List, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a “**coverage determination.**”

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 7.2 of this chapter.
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to Section 7.4 of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 7.4 of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 7.5 of this chapter.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 7.2 What is an exception?**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).** (We call it the “Drug List” for short.)

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

Section 7.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 7.4	Step-by-step: How to ask for a coverage decision, including an exception
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Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “**fast coverage decision.**” **You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5.2 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

you are requesting. (We call this the “supporting statement.”) 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. See Sections 7.2 and 7.3 of this chapter for more information about exception requests.

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form which is available on our website.

If your health requires it, ask us to give you a “fast coverage decision”

Legal Terms
A “fast coverage decision” is called an “expedited coverage determination.”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

decisions and appeals. For more information about the process for making complaints, see Section 11 of this chapter.)

Step 2: We consider your request and we give you our answer.***Deadlines for a “fast” coverage decision***

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)*****Deadlines for a “standard” coverage decision about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 7.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “**fast appeal**.”***What to do***

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called “*How to contact us when you are making an appeal about your Part D prescription drugs.*”
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 “(*How to contact our plan when you are making an appeal about your Part D prescription drugs.*)”.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *“(How to contact our plan when you are making an appeal about your part D prescription drugs).”*
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms
A “fast appeal” is also called an “expedited redetermination.”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 7.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 7.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity**.” It is sometimes called the “IRE.”

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have 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.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the 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 have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested –**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.”
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights**

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay, and know who will pay for it
 - Where to report any concerns you have about quality of your hospital care
 - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon

Legal Terms

The written notice from Medicare tells you how you can “**request an immediate review.**” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf must sign the notice. (Section 5.2 of this chapter tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Section 8.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

A “fast review” is also called an “immediate review.”

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that 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.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.3

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 Appeal?**You can appeal to us instead**

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms

A “fast” review (or “fast appeal”) is also called an **“expedited appeal.”**

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *“How to contact us when you are making an appeal about your medical care.”*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Integrated Administrative Hearing Office.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **independent review organization** called the “Office of Administrative Hearings” (OAH) reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Step 1: We will automatically forward your case to the Office of Administrative Hearings.

- We are required to send the information for your Level 2 Appeal to the Office of Administrative Hearings within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Office of Administrative Hearings does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Office of Administrative Hearings is an independent organization that is hired by Medicare.** This organization is not connected with our plan. This

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

organization is chosen by Medicare and Medicaid to handle the job of being the independent review organization. Medicare and Medicaid oversee its work.

- Reviewers at the Office of Administrative Hearings will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal**, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by the Medicare Appeals Council.

Step 3: If the Office of Administrative Hearings turns down your appeal, you choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3 and 4 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care *only*:

- **Home health care services** you are getting
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

2. **You must sign the written notice to show that you received it.**

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- You or someone who is acting on your behalf must sign the notice. (Section 5.2 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 9.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received 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, Section 4 of this booklet.)

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

What should you ask for?

- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the “ Detailed Explanation of Non-Coverage. ”

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 to your appeal?***

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you**. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. 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 another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 9.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A “fast” review (or “fast appeal”) is also called an “ expedited appeal ”.

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *“How to contact us when you are making an appeal about your medical care.”*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the **“Independent Review Organization.”**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Office of Administrative Hearings** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Step 1: We will automatically forward your case to the Office of Administrative Hearings.

- We are required to send the information for your Level 2 Appeal to the Office of Administrative Hearings within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Office of Administrative Hearings does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Office of Administrative Hearings is an independent organization that is hired by Medicare or Medicaid.** This organization is not connected with our plan. This organization is a company chosen by Medicare and Medicaid to handle the job of being the independent review organization. Medicare and Medicaid oversee its work.
- Reviewers at the Office of Administrative Hearings will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Office of Administrative Hearings will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Step 3: If the Office of Administrative Hearings turns down your appeal, you choose whether you want to take your appeal further.**

- There are two additional levels of appeal after Level 2, for a total of four levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by the Medicare Appeals Council an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3 and 4 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond**Section 10.1 Levels of Appeal 3, and 4, for Medical Service Appeals**

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down. The letter you get from the Office of Administrative Hearings (OAH) will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is a review by the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800.

Section 10.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge (called an **Administrative Law Judge**) or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is a part of the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might 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 you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice 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.

- This is the last step of the appeals process.

Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 11.1	What kinds of problems are handled by the complaint process?
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This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none">• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none">• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none">• Has someone been rude or disrespectful to you?• Are you unhappy with how our Member Services has treated you?• Do you feel you are being encouraged to leave the plan?

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Waiting times	<ul style="list-style-type: none"> • 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 Services or other staff at the plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Office of Administrative Hearings. If we do not do that within the required deadline, you can make a complaint.
Timeliness (continue)	

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 11.2 The formal name for “making a complaint” is “filing a grievance”****Legal Terms**

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 11.3 Step-by-step: Making a complaint**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You can call us at 1-800-469-6292 (TTY: 711) from 8:00 am to 8:00 pm, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
 - Send us your complaint in writing using the address listed in Chapter 2, Section 2 called: *How to contact us when you are making a complaint about your medical care.*
 - We will investigate your concerns and notify you of a decision by telephone or writing (or both) as quickly as required based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest. You will receive a letter with an explanation of the decision, which will tell you about your options to dispute if you are not satisfied with our resolution to your complaint.
 - You can also file an expedited (fast) complaint if your request is about the amount of time we took to make a coverage decision. For example, we extended the timeframe for reaching a coverage decision or denied your request for an expedited (fast) coverage decision. We will give you an answer by phone within 24 hours of receiving your complaint and mail a letter with an explanation of the decision within 3 days.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **Whether you call or write, you should contact Member Services right away.** The complaint can be made at any time after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you an answer within 24 hours.

Legal Terms

What this section calls a “**fast complaint**” is also called an “**expedited grievance**.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

**Section 11.4 You can also make complaints about quality of care to the
Quality Improvement Organization**

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - 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.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4 of this booklet. If you

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 11.5	You can also tell Medicare about your complaint
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You can submit a complaint about *VillageCareMAX Medicare Total Advantage* directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

SECTION 1	Introduction	199
Section 1.1	This chapter focuses on ending your membership in our plan.....	199
SECTION 2	When can you end your membership in our plan?	199
Section 2.1	You may be able to end your membership because you have Medicare and Medicaid	199
Section 2.2	You can end your membership during the Annual Enrollment Period	200
Section 2.3	You can end your membership during the Medicare Advantage Open Enrollment Period.....	201
Section 2.4	In certain situations, you can end your membership during a Special Enrollment Period.....	201
Section 2.5	Where can you get more information about when you can end your membership?	203
SECTION 3	How do you end your membership in our plan?	203
Section 3.1	Usually, you end your membership by enrolling in another plan	203
SECTION 4	Until your membership ends, you must keep getting your medical services and drugs through our plan	205
Section 4.1	Until your membership ends, you are still a member of our plan	205
SECTION 5	<i>VillageCareMAX Medicare Total Advantage</i> must end your membership in the plan in certain situations.....	205
Section 5.1	When must we end your membership in the plan?	205
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health	206
Section 5.3	You have the right to make a complaint if we end your membership in our plan.....	207

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan
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Ending your membership in *VillageCareMAX Medicare Total Advantage* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to

Chapter 10. Ending your membership in the plan

end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.)

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan
 - *or* – Original Medicare *without* a separate Medicare prescription drug plan.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate

Chapter 10. Ending your membership in the plan

Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 4 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

Section 2.3	You can end your membership during the Medicare Advantage Open Enrollment Period
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
 - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

Chapter 10. Ending your membership in the plan

- Usually, when you have moved
- If you have Medicaid
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions
- If we violate our contract with you
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs

Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 4 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2022* handbook.
 - Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3	How do you end your membership in our plan?
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Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

Chapter 10. Ending your membership in the plan

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from <i>VillageCareMAX Medicare Total Advantage</i> when your new plan's coverage begins. • However, you must follow the steps in Chapter 13, page 269 to end your membership on the Medicaid side in order to be completely disenrolled from the plan.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from <i>VillageCareMAX Medicare Total Advantage</i> when your new plan's coverage begins. • However, you must follow the steps in Chapter 13, page 269 to end your membership on the Medicaid side in order to be completely disenrolled from the plan.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. ○ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from <i>VillageCareMAX Medicare Total Advantage</i> when your coverage in Original Medicare begins. However, you must follow the steps in Chapter 13, page 269 to end your membership on the Medicaid side in order to be completely disenrolled from the plan.

For questions about your Medicaid benefits contact New York City Human Resources Administration at 1-888-692-6116 from 8:00 am to 5:00 pm, Monday through Friday. If you

Chapter 10. Ending your membership in the plan

disenroll and need to continue to get long-term care services, you will need to enroll in a Managed Long Term Care Plan (MLTCP), or another Medicaid Advantage Plus (MAP) Plan. Contact the New York State's Enrollment Broker at 1-888-401-6582 (TTY: 1-888-329-1541) for assistance in transferring to another plan. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan
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If you leave *VillageCareMAX Medicare Total Advantage*, it may take time before your membership ends and your new Medicare and Medicaid coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 *VillageCareMAX Medicare Total Advantage* must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

***VillageCareMAX Medicare Total Advantage* must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. **Note:** If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within three months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage during a period of deemed continued eligibility).
- If you do not pay your Medicaid spend down amount to the plan, if applicable
- If you move out of our service area.

Chapter 10. Ending your membership in the plan

- If you are away from our service area for more than ninety days.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

VillageCareMAX Medicare Total Advantage is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Chapter 10. Ending your membership in the plan

Section 5.3**You have the right to make a complaint if we end your membership in our plan**

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

Chapter 11. Legal notices

SECTION 1	Notice about governing law.....	210
SECTION 2	Notice about nondiscrimination.....	210
SECTION 3	Notice about Medicare Secondary Payer subrogation rights.....	211
SECTION 4	Notice of Privacy Practices	212

Chapter 11. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, 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, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

VillageCareMAX complies with Federal civil rights laws. VillageCareMAX does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

VillageCareMAX provides the following:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
 - ✓ Qualified sign language interpreters
 - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
 - ✓ Qualified interpreters
 - ✓ Information written in other languages

Chapter 11. Legal notices

If you need these services, contact VillageCareMAX Member Services Department at 1-800-469-6292. For TTY/TDD services, call 711.

If you believe that VillageCareMAX has not given these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with VillageCareMAX by:

Mail: Grievances Coordinator, VillageCareMAX, 112 Charles Street, New York, NY 10014

Phone: 1-800-469-6292, TTY 711

Fax: 347-226-5180

In person: Grievances Coordinator, VillageCareMAX, 112 Charles Street, New York, NY 10014

Email: complaints@villagecare.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights by:

Web: Office of Civil Rights Complaint Portal at
ocrportal.hhs.gov/ocr/portal/lobby.jsf

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F,
HHH Building Washington, D.C. 20201
Complaint forms are available at
www.hhs.gov/ocr/office/file/index.html

Phone: 1-800-368-1019, 800-537-7697 (TDD)

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, *VillageCareMAX Medicare Total Advantage*, 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 of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

VillageCareMAX has a Managed Long Term Care (MLTC) Plan, and Medicare Advantage Prescription Drug Plans (MAPD) that are offered by Village Senior Services Corporation. In order for you to obtain services through VillageCareMAX health plans, we collect, create and maintain personal health information about you. VillageCareMAX is required by law to protect the privacy of this information. This Notice of Privacy Practices describes how VillageCareMAX may use and disclose your health information, and explains certain rights you have regarding this information. VillageCareMAX is providing you this Notice in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and will comply with the terms as stated. You or your personal representative may also obtain a copy of this notice and any future amendments to it by accessing our website at www.VillageCareMAX.org or requesting a copy from our staff.

VillageCareMAX provides care management, arranges and pays for care to be provided through its participating providers. The privacy practices described in this notice will be followed by: all employees, directors and officers of VillageCareMAX; all persons and entities we contract with us and help us operate our MLTC, and MAPD plans – our "business associates."

HOW WE USE OR SHARE YOUR INFORMATION

We are committed to protecting the privacy of information we gather about you while providing your healthcare services. In this notice, when we talk about "information" or "health information" we mean information we receive directly/indirectly from you through enrollment forms such as your name, address and other demographic data; information from your transactions with us or our providers such as: medical history, health care treatment, prescriptions, health care claims and encounters, health service requests and appeal or grievance information; or financial information pertaining to your eligibility for governmental health programs or pertaining to your payment of premiums.

AUTHORIZATION REQUIRED FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, and as permitted by applicable state or federal law, we will not use or disclose your personal information without your prior written authorization. We will also not disclose your personal information for the purposes described below without your specific prior written authorization:

Chapter 11. Legal notices

- Your signed authorization is required for the use or disclosure of your protected health information for marketing purposes, except when there is a face-to face marketing communication or when we use your protected health information to provide you with a promotional gift of nominal value.
- Your signed authorization is required for the use or disclosure of your personal information in the event that we receive remuneration for such use or disclosure, except under certain circumstances as allowed by applicable federal or state law.

If you give us written authorization and change your mind, you may revoke your written authorization at any time, except to the extent we have already acted in reliance on your authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not re-disclose the information.

USES AND DISCLOSES OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

We may use your health information or share it with others as necessary in order to provide you with treatment or care, to obtain payment for that treatment or care, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment Purposes. Health information may be used or disclosed as necessary for the treatment, coordination and management of health care and related services for you by one or more health care providers, including consultation between providers regarding your care and referral of your care by VillageCareMAX or another health plan or provider to another health care provider. This would include treatment provided to you by our participating providers, such as physicians, hospitals, nursing homes and home care providers. For example, your care manager will discuss your health conditions with your doctor to plan the nursing services or physical therapy you might receive at home.

Payment. Health information about you may be disclosed as necessary for our own payment purposes and to assist in the payment activities of other health plans and health care providers. Our payment activities include obtaining premiums, determining your eligibility for benefits, reimbursing health care providers that treat you and obtaining payment from other insurers that may be responsible for providing coverage to you. For example, if a health care provider submits a bill to us for services you received, your health information may be used to determine whether these services are covered under your benefit plan and the appropriate amount of payment for the provider.

Business Operations. Health information about you may be used and disclosed to carry out health care operations, which includes, but is not limited to care management and coordination, quality

assurance and performance improvement activities, including performance evaluations of our health plans and participating providers, provider credentialing, and health plan accreditation

Chapter 11. Legal notices

activities; review of your health benefit utilization, conducting or arranging for medical reviews, audits or legal services, including fraud and abuse detection and compliance programs; specified insurance functions, business planning, development, management and administration; and business management and general administrative activities of VillageCareMAX, including but not limited to: de-identifying protected health information, creating a limited set of data for authorized purposes, actuarial analysis, resolving complaints or grievances you or your health care providers may have, and certain fundraising for the benefit of VillageCareMAX, and to assist other health plans and health care providers in performing certain health care operations, such as quality assurance, reviewing the competence and qualifications of health care network providers and conducting fraud detection.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law, including by statute, regulations or court orders.

We may also use and disclose you health information as follows:

- To authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities, including activities for preventing or controlling disease, injury or disability;
- To a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence for law enforcement purposes;
- To prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person;
- To authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.
- To conduct audits, investigations, and inspections of our health plans. The government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs, civil rights laws and other laws and regulations;
- For research purposes in limited circumstances;
- To a coroner, medical examiner, or funeral director about a deceased person;

To an organ and tissue donation organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

ADDITIONAL USES AND DISCLOSURES PERMITTED WITHOUT YOUR AUTHORIZATION

Treatment Alternatives, Benefits And Services. In the course of planning and arranging for your treatment and services we may use your health information in order to recommend to you

Chapter 11. Legal notices

possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising. To support our business operations, we may use demographic information about you, including information about your age and gender, when deciding whether to contact you or your personal representative to raise money to help us operate. We may also share this information with a charitable foundation that will contact you or your personal representative to raise money on our behalf. However, you have the right to opt not to permit these uses or receive fundraising communications by communicating that decision to us.

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us in arranging for your care, paying or arranging for payment for your care or carrying out our business operations. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

Family And Friends Involved In Your Care. Based on your informal permission and if you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition, or about the event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

Special Protections For HIV, Alcohol and Substance Abuse, Mental Health And Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information in addition to the protections described in this general Notice of Privacy Practices. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

You have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters. If you would like to exercise the rights described in this notice, please contact the Privacy Officer, 120 Broadway, Suite 2840, New York, NY, 10271 or call 212-337-5760.

Right To Inspect And Copy Records. You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you. We will respond to your

Chapter 11. Legal notices

request for inspection of records within twenty-four hours. We ordinarily will respond to requests for copies within two working days.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

Right To Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please submit your request to the Privacy Officer. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all-of-your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

Right To An Accounting Of Disclosures. You have a right to request an “accounting of disclosures” which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices.

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information;

Chapter 11. Legal notices

- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; or

Your request must state a time period within the past six years for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2014 and January 1, 2015. You have a right to receive one accounting within every 12-month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

Right To Request Additional Privacy Protections. You have the right to request that we further restrict the way we use and disclose your health information for purposes of providing or arranging for treatment, paying or arranging payment for treatment or operating our health plans. You may also request that we limit how we disclose information about you to family or friends authorized to be involved in your care. For example, you could request that we not disclose information about any treatment you received or your plan of care. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

Right To Request Confidential Communications. You have the right to request that we communicate with you or your personal representative about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how you or your personal representative wish to be contacted, and how payment for your health care will be handled if we communicate with your personal representative through this alternative method or location.

Chapter 11. Legal notices

Notification of Breach of Unsecured Protected Health Information. You will receive notification of any breach of your unsecured protected health information that we either identify ourselves or is reported to us by a Business Associate or its subcontractors.

ADDITIONAL INFORMATION

How To Obtain A Copy Of This Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time. To do so, please call VillageCareMAX at 1-800-469-6292 (TTY 711) or send a request to 112 Charles Street, New York, NY 10014. You may also obtain a copy of this notice from our website at www.VillageCareMAX.org.

How To Obtain A Copy Of Revised Notice. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information. We will post any revised notice in each of our facility reception areas. You or your personal representative will also be able to obtain your own copy of the revised notice by accessing our website at vcny.org or requesting a copy from our staff. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

How To File A Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services- Office for Civil Rights at 200 Independence Avenue S.W., Washington D.C. 20201 or call 1-877-696-6775 or go on line at www.hhs.gov/ocr/privacy/hipaa/complaints. To file a complaint with us, please contact us at 1-800-469-6292 (TTY 711). *No one will retaliate or take action against you for filing a complaint.*

CHAPTER 12

Definitions of important words

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay no copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$7,050 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Complaint — The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Chapter 12. Definitions of important words

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, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of two 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 the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as 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 are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply.

Chapter 12. Definitions of important words

Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is \$1 per day. This means you pay \$1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (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.

Chapter 12. Definitions of important words

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Home Health Aide – A home health aide 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 aides do not have a nursing license or provide therapy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

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 will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your “total drug costs including amounts you have paid and what your plan has paid on your behalf” for the year have reached \$4,430

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, 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.

Integrated Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Integrated Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan’s network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service.

Chapter 12. Definitions of important words

Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See “Extra Help.”

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part B Premium, and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1. Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

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

Chapter 12. Definitions of important words

(generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Chapter 12. Definitions of important words

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 Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. 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 we use 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. We call them “**network providers**” when they 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. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

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 two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Chapter 12. Definitions of important words

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “**Medicare Advantage (MA) Plan.**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

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 are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both 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.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other

Chapter 12. Definitions of important words

network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are 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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. 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. The plan may disenroll you if you permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

***VillageCareMAX Medicare Total Advantage* (HMO D-SNP) Member Services**

Method	Member Services – Contact Information
CALL	1-800-469-6292 Calls to this number are free. Seven days a week 8:00 am to 8:00 pm. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Seven days a week from 8:00 am to 8:00 pm.
FAX	212-337-5711
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014
WEBSITE	www.villagecaremax.org

Health Insurance Information, Counseling and Assistance Program (HIICAP): (New York's SHIP)

Health Insurance Information, Counseling and Assistance Program (HIICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York's SHIP) – Contact Information
CALL	1-800-701-0501
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	2 Lafayette Street, 7th Floor New York, NY 10007-1392
WEBSITE	www.aging.ny.gov/healthbenefits/

Chapter 13

*VillageCareMAX Medicare Total
Advantage (HMO D-SNP)*

*New York State Medicaid Advantage
Plus (MAP) Member Handbook*

Welcome to VillageCareMAX!

VillageCareMAX Medicare Total Advantage (HMO D-SNP) is a Medicare Advantage and a Medicaid Advantage Plus (MAP) program. This means, we cover your Medicare and Medicaid benefits under one plan. The previous chapters reviewed the Medicare benefits and rules under the Medicare Advantage part of the plan. This chapter tells you about your Medicaid benefits and rules under the Medicaid Advantage Plus part of the plan. You can find information on how to request a service, file a complaint (grievance) and the enrollment and disenrollment process. Please refer to information in both the Evidence of Coverage for Medicare Advantage in the previous chapters and this Medicaid Advantage Plus (MAP) Member Handbook chapter for complete plan information.

We urge you to review this handbook carefully. Please feel free to ask questions about the Plan by either calling or writing:

VillageCareMAX
112 Charles Street
New York, NY 10014
1-800-469-6292
TTY 711

If you do not speak English, VillageCareMAX will provide you with staff and/or translation services to communicate with you in person or by telephone in whatever language you speak. This is a free service. Also, written material from VillageCareMAX is available in Spanish and Chinese.

If you have a special hearing or vision need, VillageCareMAX will be happy to accommodate you. Arrangements will be made on an individual basis as necessary. This is also a free service to all members of VillageCareMAX.

Important

VillageCareMAX

Telephone Numbers:



Member Services

7 days a week

8 a.m. to 8 p.m.

VillageCareMAX

1-800-469-6292

Toll-Free Number

TTY 711

During non-business hours, our answering service will be happy to take your message and will contact on-call staff to assist you. The person on-call will contact you as soon as possible. Assistance is available 24 hours a day, 7 days a week. The Physician Call Line is also available 24 hours per day at 1-844-484-7362 (TTY: 711) to speak to a physician about your non-emergency health related concerns.

Table of Contents

What Makes VillageCareMAX Special?	234
Who Is Eligible To Join VillageCareMAX?	235
How Do I Enroll?	236
Which Providers Can I Use?	238
What Medicaid Services Are Covered By VillageCareMAX	241
What Medicaid Services Are Not Covered By VillageCareMAX?	249
How Do I Get The Services That I Need? Service Authorizations and Actions	251
What to do if you have a complaint about your Plan or want to appeal a decision about your care?	261
Can I Leave The Plan?	262
What Are My Rights and Responsibilities?	264
Money Follows the Person (MFP)/Open Doors	267
Notice of Non-Discrimination	268

What Makes VillageCareMAX Special?

When you enroll in VillageCareMAX Medicare Total Advantage Plan, you are covered for a broad range of services that are designed to keep you safe in your home. A team of health care professionals will work closely with you to help you get the care you need. This team of health care professionals (your care team) is made up of your primary care doctor, a social worker, a member service representative, your caregivers, and your VillageCareMAX Care Manager, who is a Registered Nurse. Your care manager will lead your care team, making sure that you get the care you need and teach you ways to stay as healthy as possible. The care you need may include Medicaid covered long-term care services such as home care, personal care, rehabilitative therapies and adult day health care.

Your Care Manager will visit your home on a schedule determined by your health care needs to make sure that you are doing well, and to make sure that you have what you need to keep you living safely at home for as long as possible. Your Care Manager will assess your health care needs on an ongoing basis with you and your care team. He/she will make sure that you have a plan of care that is just right for you and that meets your health care needs. Your plan of care will include the covered and coordinated services that you need to meet the goals and outcomes that you and care team want to achieve. Working with your care team, your Care Manager will formally evaluate your plan of care every six months, or more frequently if your condition changes and he or she will make sure that the covered and coordinated services that you need to stay well and keep living safely at home are in place.

One of the many nice things about VillageCareMAX is that if you need anything or have any questions, all you have to do is call our toll free member services number to get help. One of our member service representatives will answer the phone. They can help you with your questions and they can help you get the care you need by putting you in touch with your care manager, if that is what is needed. Your member service representatives will be working with you very closely throughout your membership, so please feel free to ask for him or her when you call. Just remember, all of our member service representatives are trained and ready to help you.

VillageCareMAX is sensitive to the needs of its members. We will provide for the needs of hearing/vision-impaired members by offering services such as documentation with enlarged print and TTY service. VillageCareMAX has the ability to communicate with all members in their native language either directly through Plan employees or through a translation service. This service is free of charge to our members. In addition, our Member Handbook and written materials are available in English, Spanish, and Chinese.

VillageCareMAX values its members and we are here to help you. From time to time, we will ask you for your advice on how we can make the Plan better, how we can make

it easier for you to get the care you need and how we can improve the quality of services that we provide to you. Your input is important to us and important to your care. If you need to tell us something about your care, you can do that at any time by calling Member Services at 1-800-469-6292 (TTY: 711).

Who is Eligible to Join VillageCareMAX?

A Registered Nurse will assess you and determine if you are eligible to join VillageCareMAX. To enroll in VillageCareMAX Medicare Total Advantage you must:

1. Be at least 18 years of age.
2. Be a resident of the Bronx, Brooklyn, Manhattan or Queens.
3. Have full Medicaid coverage
4. Have evidence of Medicare Part A & B coverage; or be enrolled in Medicare Part C coverage
5. Be eligible for nursing home level of care (as of the time of enrollment)
6. Be able to stay safely at home and in the community at the time of enrollment
7. Show a need and require one of the following Community Based Long Term Care Services (CBLTCS) for a continuous period of more than 120 days from the effective date of enrollment:
 - Nursing services in the home
 - Therapies in the home
 - Health aide services in the home
 - Personal care services in the home
 - Consumer directed personal assistance services
 - Adult day health care
 - Private duty nursing
8. Enroll in the Medicare Advantage plan under VillageCareMAX Medicare Total Advantage

VillageCareMAX will not discriminate against any potential enrollee who meets the above criteria based on their health status and need for, or cost, of covered services.

During the enrollment process, if it is determined that you are not eligible for enrollment, you will be advised and will be given an opportunity to withdraw your application.

You cannot enroll in VillageCareMAX Medicaid Advantage Plus program if you are a resident of a residential facility of the State Office of Mental Health (OMH); the Office of Alcoholism and Substance Abuse Services (OASAS); the State Office of People With Developmental Disabilities (OPWDD) or OPWDD Day Treatment Program; enrolled in

another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, or a Comprehensive Medicaid Case Management Program (CMCM). However, you can enroll in VillageCareMAX Medicare Total Advantage after you disenroll from these programs and meet the other eligibility requirements.

How do I enroll?

VillageCareMAX processes requests for enrollment in the order in which they are received. Enrolling in VillageCareMAX is easy. You or your family/caregiver or another person who helps you obtain services may contact VillageCareMAX by phone. A VillageCareMAX representative will talk to you and explain the program. He/she will determine that you meet age requirements, reside in our service area, and have Medicaid & Medicare benefits. If you don't already have Medicaid but are interested in applying for Medicaid benefits, our staff can also help you with your Medicaid application.

Our staff can help you each step of the way, as outlined below.

You may enroll in two ways:

1. **You can call VillageCareMAX at 1-800-469-6292. TTY users, call 711.** If you are new to Community Based Long Term Care Services, we will talk with you about your health needs and put you in touch with the New York State Department of Health Conflict Free Evaluation and Enrollment Center (CFEEC). A Registered Nurse from the CFEEC will visit your home to complete an evaluation and decide if you are eligible to enroll in the plan. If CFEEC determines that you are eligible for enrollment, they will refer you back to VillageCareMAX or another plan you choose.
 - a. After you complete your evaluation with CFEEC, you may tell the Nurse that you want to enroll in VillageCareMAX Medicare Total Advantage Plan. The nurse from CFEEC can help you schedule a second assessment by the plan you choose.
 - b. We will contact you to schedule an appointment with our enrollment nurse in your home.
 - c. At the time of your appointment, our enrollment nurse will come to your home to complete a physical, social and environmental assessment of you and your home. The nurse will ask about your past and current health status. If you are eligible based on the assessment done by our enrollment nurse, he/she will review important information about the program and talk with you about the services you would receive at the time your enrollment in VillageCareMAX is approved and effective.
2. **You may also call Conflict Free Evaluation and Enrollment center at: 1-855-222-8350 Monday-Friday, from 8:30 am to 8:00 pm and Saturday, from 10:00 am to 6:00 pm.**

If you are transferring from another Managed Long Term Care Plan (MLTC) or Medicaid Advantage Plus (MAP) program, you should **call the State's enrollment broker at: 1-888-401-6582. TTY: 1-888-329-1541.**

The state's enrollment staff will ask you which plan you wish to join. If you selected VillageCareMAX, our staff will contact you to arrange a time for a registered nurse to come to your home. The nurse will talk with you about the plan in more detail, will complete an assessment of your needs, and talk with you about the services you need as a member of VillageCareMAX.

Since VillageCareMAX Medicare Total Advantage also covers Medicare services, a licensed Medicare Marketing Representative will visit you to review important plan information, and assist with completing your Medicare application to enroll you in the Medicare Advantage part of VillageCareMAX Medicare Advantage. The representative will also review Medicaid-covered benefits, and assist with completing the Medicaid enrollment agreement to enroll you in the Medicaid Advantage Plus part of VillageCareMAX Medicare Total Advantage. This will allow VillageCareMAX to process your enrollment request to get both your Medicare and Medicaid benefits from VillageCareMAX Medicare Total Advantage Plan.

Once all of the above is complete, your enrollment request will be submitted to Medicaid and Medicare for approval. They are responsible for processing all enrollments.

- If Medicaid receives the completed enrollment package by the 20th day of the month, the enrollment will take effect on the first day of the next month. (For example: If your completed enrollment package is submitted by January 20, your enrollment would take place on February 1.)
- If Medicaid receives the enrollment package after the 20th day of the month, the enrollment must take effect no later than the first day of the second month. (For example: If your completed enrollment package is submitted on January 22, your enrollment would take place on March 1.)

If you change your mind and choose not to enroll in the program, you can withdraw your application at any time before your enrollment becomes effective. VillageCareMAX will notify Medicaid and Medicare as appropriate, and will mail you a confirmation of cancellation letter. If your enrollment request was already sent to Medicare and Medicaid, the Plan must receive approval or notification from both Medicare and Medicaid to cancel your enrollment. You can cancel your enrollment in the Medicaid Advantage Plus (MAP) part of the plan before noon of the 20th day before your enrollment becomes effective. If your enrollment request was already sent to Medicare, your last day to cancel your enrollment in the Medicare Advantage part of the plan will be included in the enrollment verification letter mailed to you from VillageCareMAX. As much as possible, the Plan will work with you to ensure that the effective date of cancellation is the same for from both Medicare and Medicaid.

During the enrollment process, if it is found that you are not eligible for enrollment into VillageCareMAX, you will be informed in writing of the decision. Anytime your enrollment is going to be denied, Medicaid must approve this decision.

VillageCareMAX will deny your enrollment under the following conditions:

- You do not meet the eligibility criteria listed above;
You do not need community-based long-term care services of the Plan for a continuous period of more than 120 days;
- You are enrolled in one of the following: another managed care plan capitated by Medicaid, a Traumatic Brain Injury or Nursing Home Transition and Diversion Waiver program, a hospice, a State Office for People with Developmental Disabilities (OPWDD) program and you do not want to disenroll from any of these services;
- You are a resident of psychiatric facility, alcohol/substance abuse long term residential treatment or assisted living programs;
- You are expected to have Medicaid for less than 6 months, have Emergency Medicaid or are in Medicaid family planning expansion program;
- You are in the Foster Family Care Demonstration;
- You are a resident of an Assisted Living Program (ALP)

Once your enrollment has been confirmed by Medicaid and Medicare, you will receive a confirmation of enrollment letter that will include your effective date of enrollment. In addition, VillageCareMAX will mail you important documents including your Member ID Card, Welcome Kit and Over-the-Counter (OTC) card. If you don't have your Member ID card and need to see a doctor, call Member Services to verify your coverage and they will fax your eligibility information to your provider. If you received your confirmation of enrollment letter, you may also use this letter as a proof of coverage until you get Member ID card.

Which Providers Can I Use?

We have a network of qualified providers including: home care agencies, dentists, podiatrists, optometrists, audiologists and other providers. You will receive a VillageCareMAX provider directory which is a list of network providers with their names, addresses, phone numbers and languages spoken. You will receive this list when you enroll. From time to time we update the directory. You can find up-to-date directory on our website at www.villagecaremax.org or call us at 1-800-469-6292 (TTY: 711), and we will send you one by mail. You will also receive updated information on our providers throughout the year when there is a change in providers or their information. VillageCareMAX has a veteran's home in its network. Long term placement in veteran's home is available to each veteran, spouse of a veteran, and Gold Star parent member. Please let VillageCareMAX know if need services in a veteran's home.

Using an Out-Of-Network Provider

As a member of VillageCareMAX, you must use our network providers for covered services except in certain cases. VillageCareMAX will cover services you get from providers who are not part of the plan's network in these cases:

1. If you receive emergency care or urgently needed services
2. Kidney dialysis services when you are temporarily outside the plan's service area
3. If you need medical care that Medicare or Medicaid requires our plan to cover and the providers in our network cannot provide this care. You must obtain prior authorization from VillageCareMAX before getting care from the out-of-network provider
4. If you are a new member and you are receiving long-term care services from fee for service Medicaid, like personal care, adult day health care, care in the nursing home and others, we must continue to cover these services for at least 90 days after you join the plan.
5. If you are enrolled in the Plan and your network provider leaves VillageCareMAX network, we will continue to cover the services that you are receiving from the provider for up to 90 days, in order to facilitate transition to another provider. Providers must agree to accept VillageCareMAX payment as payment in full and adhere to a Quality Improvement program during the transition period.

Access Standards

VillageCareMAX expects our network providers to give you prompt service. We have told our providers that they need to see and treat you within the following time-frames:

Service	Standard
Optical Appointments:	Appointment within two (2) weeks of the date you called to arrange the appointment.
Dental Appointments:	Appointment within two (2) weeks of the date you called to arrange the appointment.
Podiatry Appointments:	Appointment within two (3) weeks of the date you called to arrange the appointment.
Home Nursing Appointments:	Within 48 hours of request unless otherwise required by your doctor.
Home Rehab Appointments:	Within 48 hours of request unless otherwise required by your doctor.
Non-emergency Transportation	Will be arranged as needed for medical appointments. Please call to arrange for transportation 24-48 hours in advance.

Emergency Services

If you have a medical emergency, you do not need to get approval from VillageCareMAX or a referral from your PCP.

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or your family should call Member Services to tell us about your emergency care within 48 hours or as soon as possible. This will enable the program to cancel scheduled appointments, or if you are hospitalized, to work with hospital personnel to plan for your discharge and follow-up care.

Emergency Services is a “medical emergency” which is a medical or behavioral condition that causes acute symptoms of sufficient severity including severe pain, such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part of such person; or 4) serious disfigurement of such person.

What to do after an Emergency?

Once your condition has been stabilized, we will work with your care team to monitor your health and ensure a safe discharge when appropriate. If you receive emergency care at an out-of-network hospital and need inpatient care or additional services after your emergency condition is stabilized, you must go to an in-network hospital or obtain authorization from the Plan.

Urgent Care

If the situation is not an emergency, but you need same day medical care, notify Member Services or call your physician directly. Member Services can assist you with arrangements and transportation to your medical appointment.

Urgently needed services are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Our plan does not cover urgently needed services or any other care if you receive the care outside of the United States.

Changing Providers

Your nurse Care Manager will arrange for all medically necessary services. If you have or are receiving services from one of our network providers and wish to switch providers, please call Member Services and inform them of your request. Member Services will ask you some questions such as why you are requesting to change providers. If necessary, Member Services will put you in touch with your Care Manager. It is important for us at VillageCareMAX to know if you are not happy with any of our network providers. We will work with you in resolving any concerns you may have regarding a provider, or changing providers if necessary.

Generally, whenever you need a service you may call your nurse Care Manager. Your Care Manager can be reached by calling Member Services at 1-800-469-6292 (TTY 711). If you have any questions about the Plan, please call Member Services. You will be put in touch with a staff member who can answer your question or help you with your concern.

Leaving the Service Area

If you leave the service area for 30 days or less on a short vacation or to visit friends/relatives and believe that you need any services covered by VillageCareMAX, contact Member Services at 1-800-469-6292 (TTY 711). Member Services will put you in touch with your Care Manager. To avoid any problems while you are out of the service area, call Member Services prior to leaving. VillageCareMAX will work with you to plan or arrange for services that are needed. However, if you require emergency or urgent medical care while you are away, seek the care that you need, and then contact your Member Services.

If you leave the service area for more than 30 days, we will have to disenroll you from the Plan.

What Medicaid Services are Covered by VillageCareMAX Medicaid Advantage Plus (MAP) Program?

Chapter 4 lists Medicare-covered benefits that you can get from the plan such as inpatient and outpatient hospital services, doctor's visits, emergency services, laboratory tests, and many more. See Chapter 4 to view a complete list of Medicare-covered benefits. The section below explains the Medicaid-covered benefits and coverage rules. You do not have to pay any deductibles, copayments or premiums for covered services.

Service	Coverage Rules
Adult Day Health Care Provides care and services in a residential health care facility or approved extension site. Adult Day Health Care includes the following services: medical, nursing, food and nutrition,	You must get Adult Day Health Care from the VillageCareMAX Provider Network, and you must get authorization from the Plan. Your doctor will need to

Service	Coverage Rules
<p>Adult Day Health Care (continued)</p> <p>social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as leisure time activities that are a planned program of diverse and meaningful activities. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services.</p>	<p>provide signed written orders to the Adult Day Health Care provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p>
<p>Audiology/Hearing Aids not covered by Medicare</p> <p>Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.</p>	<p>You must get audiology/hearing aids from the VillageCareMAX Provider Network. Prior authorization may be required.</p>
<p>Care Management by a Registered Nurse or Social Worker</p> <p>Your care manager will assist you with getting the covered services identified in the Person Centered Service Plan (PCSP). This includes help with referral, assistance in or coordination of medical, social, educational, psychosocial, financial and other services in support of your PCSP. The services may not always be covered by VillageCareMAX.</p>	<p>Every member has a Care Manager.</p>
<p>Consumer Directed Personal Assistance</p> <p>This is a self-directed program where a member or a person acting on a member's behalf, known as a designated representative, directs and manages the member's personal care services, home health aide services or skilled nursing tasks. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping. This is provided by an aide chosen and directed by the member or a designated representative.</p>	<p>You must coordinate your consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX. Prior authorization is required from VillageCareMAX.</p>
<p>Dental</p> <p>Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.</p>	<p>You must get dental services from the VillageCareMAX dental Provider Network provided by Healthplex.</p>

Service	Coverage Rules
<p>Durable Medical Equipment (DME) not covered by Medicare</p> <p>Durable medical equipment is made up of devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition. Durable medical equipment covered by Medicaid includes items such as tub stools, grab bars, medical/surgical supplies, and enteral formula that are not otherwise covered by Medicare.</p>	<p>You must get items from the VillageCareMAX Provider Network and get prior authorization from the plan for certain items. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p>
<p>Home-Delivered Meals and/or Meals in a Group Setting</p> <p>Services include meals that are delivered at home or in a group setting for individuals who are unable to prepare meals or unable to get assistance with meal preparation.</p>	<p>You must get home delivered or congregate meals from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.</p>
<p>Home Health Care Services Not Covered by Medicare</p> <p>Medicaid-covered home health services include the provision of skilled services not covered by Medicare. VillageCareMAX Medicare Total Advantage coordinates the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health.</p>	<p>You must get home health care services from the VillageCareMAX Provider Network. Services are based on a plan of care that your physician approves, and all services are provided in your home. Prior authorization is required from VillageCareMAX.</p>
<p>Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit</p> <p>Services include mental health care services that require a hospital stay. Medicaid covers the deductible and cost of the days in excess of the Medicare 190-day lifetime limit. There is no limit to the number of days covered by the plan each hospital stay. You are covered for up to 365 days per year (366 in a leap year) with no deductible or copayment.</p>	<p>You must get inpatient mental health services from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.</p>
<p>Medical Social Services</p> <p>These services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of your needs in your home when such services are performed by a qualified social worker. Medical social services will assist you with concerns related to your illness, finances, housing or environment.</p>	<p>You must get Medical Social Services from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies</p> <p>Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and device and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, and administered for a specific purpose</p>	<p>These items may be covered by Medicare. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p>
<p>Non-emergency Transportation</p> <p>Non-Emergency Transportation is transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member's condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.</p>	<p>You must get non-emergency transportation from the VillageCareMAX Provider Network, and call VillageCareMAX two days in advance to schedule transportation.</p>
<p>Nursing Home Care not covered by Medicare</p> <p>Medicaid-covered care provided in a Skilled Nursing Facility</p>	<p>Your doctor will need to provide signed written orders to the nursing home. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network provider and get authorization from the Plan.</p>
<p>Nutrition Services/Counseling</p> <p>Services include the assessment of nutritional needs for your physical and medical needs and environmental conditions. These include the provision of nutrition education and counseling to meet your therapeutic needs and development of a nutritional treatment plan.</p>	<p>You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network, and you must get authorization from the Plan.</p>
<p>Optometry/Eyeglasses</p> <p>Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses</p>	<p>You must get optometry services and eyeglasses from the VillageCareMAX Provider Network. Prior authorization may be required.</p>

Service	Coverage Rules
Optometry/Eyeglasses (continued) and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.	
Outpatient Mental Health & Substance Abuse Services to treat mental health and substance abuse conditions in an outpatient setting.	<p>You must get outpatient mental health & substance abuse services from the VillageCareMAX Provider Network.</p> <p>You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period. Prior authorization is only required for out-of-network service requests, electroconvulsive therapy (ECT), and neuropsychological testing.</p>
Personal Care Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks.	<p>You must get personal care from the VillageCareMAX Provider Network, and you must get authorization from the Plan. Your doctor will need to provide signed written orders to the agency providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p>
Personal Emergency Response Systems (PERS) PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	<p>You must get PERS from the VillageCareMAX Provider Network, and you must get authorization from the Plan.</p>
Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction	<p>VillageCareMAX will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.</p>

Service	Coverage Rules
<p>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home (continued)</p> <p>of physical or mental disability and restoration of the member to his or her best functional level.</p> <p>Occupational therapy is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p> <p>Speech-language therapy is rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p>	<p>Your doctor will need to provide signed written orders to the Rehabilitation Therapist. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>You can get services from or outside of the VillageCareMAX Provider Network and get authorization from the Plan.</p>
<p>Podiatry services not covered by Medicare</p> <p>Podiatry means services by a podiatrist, which must include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.</p>	<p>You can get podiatry services from or outside of the VillageCareMAX Provider Network.</p>
<p>Private Duty Nursing</p> <p>Private Duty Nursing are medically necessary services provided at enrollee's permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).</p>	<p>You must get private duty nursing services from the VillageCareMAX Provider Network and requires a doctor's order. Prior authorization is required from VillageCareMAX.</p>
<p>Prosthetics, Orthotics and Orthopedic Footwear</p> <p>Prosthetic appliances and devices are appliances and devices that replace any missing part of the body.</p> <p>Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.</p>	<p>You must get items from the VillageCareMAX Provider Network, and get prior authorization from the plan. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in</p>

Service	Coverage Rules
<p>Prosthetics, Orthotics and Orthopedic Footwear (continued)</p> <p>Orthopedic footwear includes shoes, shoe modifications or shoe additions that are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot. Orthopedic footwear also is used to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p>	<p>obtaining doctor's orders if needed.</p>
<p>Respiratory Therapy</p> <p>The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.</p>	<p>You must get respiratory therapy from the VillageCareMAX Provider Network, and you must get authorization from the Plan. Your doctor will need to provide signed written orders to the therapist providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p>
<p>Social and Environmental Supports</p> <p>Social and environmental supports are services and items that maintain the medical needs of the member and include the following: home maintenance tasks, homemaker/chore services, housing improvement and respite care.</p>	<p>You must get social and Environmental supports from the VillageCareMAX Provider Network, and you must get authorization from the Plan.</p>
<p>Social Day Care</p> <p>Social day care is a structured program that provides functionally impaired individuals with socialization, supervision, monitoring and nutrition in a protective setting during any part of the day. Additional services may include personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.</p>	<p>You must get Social day care from the VillageCareMAX Provider Network, and you must get authorization from the Plan.</p>
<p>Telehealth</p> <p>Telehealth is the use of technologies to deliver or support clinical health care for covered services from a distance to reduce the need for in-office visits. The services include live video between a member and a provider; transmission of recorded health history through a secure electronic communications system; and use of mobile devices to provide supportive services.</p>	<p>Telehealth can be received to support covered services only.</p> <p>You must get authorization from the Plan.</p>

Service	Coverage Rules
<p>Veteran’s Home Services</p> <p>If you are a veteran, spouse of a veteran, or Gold Star parent in need of long term nursing home services, you may access Veteran’s Home Services.</p>	<p>If VillageCareMAX does not have an accessible in-network veteran’s home, the plan will authorize out-of-network services until member is transferred to another plan with an in-network veteran’s home.</p> <p>You must get authorization from the Plan.</p>

Limitations

PLEASE NOTE: Several of the benefits outlined above are subject to benefit limitations. This means that you are entitled to only a certain amount of service each year, or you must meet additional eligibility criteria. The benefit limits for VillageCareMAX are listed below:

- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Nursing Home Care is covered for individuals who are considered a permanent placement, provided you are eligible for institutional Medicaid coverage.

You must get these services from the providers who are in VillageCareMAX network. If you cannot find a provider in our plan, please call Member Services at 1-800-469-6292. TTY users, please call 711.

What Medicaid Services are not Covered by VillageCareMAX Medicare Total Advantage Plan?

Medicaid Services not Covered by VillageCareMAX Medicare Total Advantage

There are some Medicaid services that VillageCareMAX does not cover. However, these services may be included in your plan of care and coordinated by your Care Manager. You should speak with your Care Manager and your Doctor if you need any of these services.

You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-800-469-6292 (TTY: 711) if you have a question about whether a benefit is covered by VillageCareMAX Medicare Total Advantage or Medicaid.

Service	Description
Certain Mental Health Services	<p>The following services are covered through Medicaid Fee-for-Service:</p> <ul style="list-style-type: none"> • Intensive Psychiatric Rehabilitation Treatment • Day Treatment • Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units) • Partial Hospital Care not covered by Medicare • Rehabilitation Services to those in community homes or in family-based treatment • Continuing Day Treatment • Assertive Community Treatment • Personalized Recovery Oriented Services
Directly Observed Therapy (DOT) for Treatment of Tuberculosis	<p>Services are covered through Medicaid Fee for Service, which include direct observation of oral ingestion of TB medications to ensure compliance with prescribed medication.</p>
Family Planning	<p>Services are covered through Medicaid Fee for Service, which include medical treatment such as vasectomies or tubal ligation.</p>

Service	Description
	Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).
Hospice Care	Hospice services are covered through Medicare Fee for Service, which include a range of home-based and inpatient services for people at the end of life.
Medicaid-covered Prescription Drugs	Certain drugs excluded from the Medicare Part D drug benefit may be covered by Medicaid. Use your Medicaid card to get Medicaid-covered prescription drugs.
Methadone Maintenance Treatment Program (MMTP)	MMTP services are covered through Medicaid Fee for Service, which include drug detoxification, drug dependence counseling, and rehabilitation services which include chemical management of the patient with methadone.
Office for People with Developmental Disabilities	Services are covered through Medicaid Fee for Service, which include services received through the New York State Office for People with Developmental Disabilities such as day programs and vocational training.
Over-the-Counter Drugs	Some health products may be available to you through Medicaid by using your Medicaid Benefit ID card.
Other Medicaid Services	<p>The following services are covered through Medicaid Fee-for-Service:</p> <ul style="list-style-type: none"> • Assisted Living Program • AIDS Adult Day Health Care • Comprehensive Medicaid Case Management • Home and Community Based Waiver Program Services • Rehabilitation services provided to residents of OMH licensed Community Residences and Family Based Treatment Programs

Services not Covered by Medicaid or VillageCareMAX Medicare Total Advantage Plan

You must pay for non-covered services that you agree to get even though VillageCareMAX or your provider tells you that services are not covered. Some examples of services that are not covered by VillageCareMAX Medicare Total Advantage or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services of a Provider that is not part of the plan (unless VillageCareMAX Medicare Total Advantage sends you to that provider)

You can speak with your Care Manager or Member Services, if you have any questions about covered and non-covered services.

How Do I Get the Services That I Need? Service Authorizations and Actions

When you enroll, you and your care team (your doctor, your Care Manager, your caregiver(s), Member Services and other health care providers) will work together to develop a plan of care that meets your needs. The plan of care is a written description of all the services you need. It is based on an assessment of your health care needs, the recommendation of your doctors and your personal preferences. You will be given a copy of the plan of care for your records, which will include a listing of how often and how long you will receive the services included in your plan of care.

Your Care Manager will follow-up with you on regular basis to check on your health care status by visiting you in your home or calling you on the phone. He/she will work with your physician, and other health care providers, to ensure that you are receiving all needed and ordered service.

Service Authorizations and Actions

When VillageCareMAX Medicare Total Advantage determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from VillageCareMAX Medicare Total Advantage before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

Service	Coverage Rules
Adult Day Health Care Provides care and services in a residential health care facility or approved extension site. Adult Day Health Care includes	You must get Adult Day Health Care from the VillageCareMAX Provider Network. Your doctor will need to provide signed

Service	Coverage Rules
<p>the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as leisure time activities that are a planned program of diverse and meaningful activities. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services.</p>	<p>written orders to the Adult Day Health Care provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX</p>
<p>Audiology/Hearing Aids not covered by Medicare</p> <p>Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.</p>	<p>You must get audiology/hearing aids from the VillageCareMAX Provider Network.</p> <p>Prior authorization may be required from VillageCareMAX.</p>
<p>Consumer Directed Personal Assistance</p> <p>This is a self-directed program where a member or a person acting on a member's behalf, known as a designated representative, directs and manages the member's personal care services, home health aide services or skilled nursing tasks. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping. This is provided by an aide chosen and directed by the member or a designated representative.</p>	<p>You must coordinate your consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Dental</p> <p>Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.</p>	<p>You must get dental services from the VillageCareMAX dental Provider Network provided by Healthplex.</p> <p>Prior authorization may be required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Durable Medical Equipment (DME) not covered by Medicare</p> <p>Durable medical equipment is made up of devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition. Durable medical equipment covered by Medicaid includes items such as tub stools, grab bars, medical/surgical supplies, and enteral formula that are not otherwise covered by Medicare.</p>	<p>You must get items from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX for certain items.</p>
<p>Home-Delivered Meals and/or Meals in a Group Setting</p> <p>Services include meals that are delivered at home or in a group setting for individuals who are unable to prepare meals or unable to get assistance with meal preparation.</p>	<p>You must get home delivered or congregate meals from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Home Health Care Services Not Covered by Medicare</p> <p>Medicaid-covered home health services include the provision of skilled services not covered by Medicare. VillageCareMAX Medicare Total Advantage coordinates the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health.</p>	<p>You must get home health care services from the VillageCareMAX Provider Network. Services are based on a plan of care that your physician approves, and all services are provided in your home.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit</p> <p>Services include mental health care services that require a hospital stay. Medicaid covers the deductible and cost of the days in excess of the Medicare 190-day lifetime limit. There is no limit to the number of days covered by the plan each hospital stay. You are covered for up to 365 days per year (366 in a leap year) with no deductible or copayment.</p>	<p>You must get inpatient mental health services from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Medical Social Services</p> <p>These services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of your needs in your home when such services are performed by a qualified social worker. Medical social services will assist you with concerns related to your illness, finances, housing or environment.</p>	<p>You must get Medical Social Services from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies</p> <p>Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and device and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, and administered for a specific purpose</p>	<p>These items may be covered by Medicare. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Non-emergency Transportation</p> <p>Non-Emergency Transportation is transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member’s condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.</p>	<p>You must get non-emergency transportation from the VillageCareMAX Provider Network, and call VillageCareMAX two days in advance to schedule transportation.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Nursing Home Care not covered by Medicare</p> <p>Medicaid-covered care provided in a Skilled Nursing Facility</p>	<p>Your doctor will need to provide signed written orders to the nursing home. VillageCareMAX will assist your provider in obtaining doctor’s orders if needed.</p> <p>Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network provider.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Nutrition Services/Counseling</p> <p>Services include the assessment of nutritional needs for your physical and medical needs and environmental conditions. These include the provision of nutrition education and counseling to meet your therapeutic needs and development of a nutritional treatment plan.</p>	<p>You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Optometry/Eyeglasses</p> <p>Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.</p>	<p>You must get optometry services and eyeglasses from the VillageCareMAX Provider Network.</p> <p>Prior authorization may be required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Outpatient Mental Health & Substance Abuse</p> <p>Services to treat mental health and substance abuse conditions in an outpatient setting.</p>	<p>You must get outpatient mental health & substance abuse services from the VillageCareMAX Provider Network.</p> <p>You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period.</p> <p>Prior authorization is only required for out-of-network service requests, electroconvulsive therapy (ECT), and neuropsychological testing.</p>
<p>Personal Care</p> <p>Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks.</p>	<p>You must get personal care from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the agency providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Personal Emergency Response Systems (PERS)</p> <p>PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.</p>	<p>You must get PERS from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home</p> <p>Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p>	<p>VillageCareMAX will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.</p> <p>Your doctor will need to provide signed written orders to the Rehabilitation Therapist.</p>

Service	Coverage Rules
<p>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home (continued)</p> <p>Occupational therapy is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p> <p>Speech-language therapy is rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p>	<p>VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>You can get services from or outside of the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Podiatry services not covered by Medicare</p> <p>Podiatry means services by a podiatrist, which must include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.</p>	<p>You can get podiatry services from or outside of the VillageCareMAX Provider Network.</p>
<p>Private Duty Nursing</p> <p>Private Duty Nursing are medically necessary services provided at enrollee's permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).</p>	<p>You must get private duty nursing services from the VillageCareMAX Provider Network and requires a doctor's order.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Prosthetics, Orthotics and Orthopedic Footwear</p> <p>Prosthetic appliances and devices are appliances and devices that replace any missing part of the body.</p> <p>Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.</p>	<p>You must get items from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the provider.</p> <p>VillageCareMAX will assist</p>

Service	Coverage Rules
<p>Prosthetics, Orthotics and Orthopedic Footwear (continued)</p> <p>Orthopedic footwear includes shoes, shoe modifications or shoe additions that are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot. Orthopedic footwear also is used to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p>	<p>your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Respiratory Therapy</p> <p>The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.</p>	<p>You must get respiratory therapy from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the therapist providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Social and Environmental Supports</p> <p>Social and environmental supports are services and items that maintain the medical needs of the member and include the following: home maintenance tasks, homemaker/chore services, housing improvement and respite care.</p>	<p>You must get social and Environmental supports from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Social Day Care</p> <p>Social day care is a structured program that provides functionally impaired individuals with socialization, supervision, monitoring and nutrition in a protective setting during any part of the day. Additional services may include personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.</p>	<p>You must get Social day care from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Telehealth</p> <p>Telehealth is the use of technologies to deliver or support clinical health care for covered services from a distance to</p>	<p>Telehealth can be received to support covered services only.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
Telehealth (continued) reduce the need for in-office visits. The services include live video between a member and a provider; transmission of recorded health history through a secure electronic communications system; and use of mobile devices to provide supportive services.	
Veteran's Home Services If you are a veteran, spouse of a veteran, or Gold Star parent in need of long term nursing home services, you may access Veteran's Home Services.	If VillageCareMAX does not have an accessible in-network veteran's home, the plan will authorize out-of-network services until member is transferred to another plan with an in-network veteran's home. Prior authorization is required from VillageCareMAX.

When you ask for approval for a treatment or service, it is called a **service authorization request**. To get a service authorization request, you must get approval for these treatments or services. You, your doctor, or designated representative may call Member Services at 1-800-469-6292 (TTY: 711) from 8:00 am to 8:00 pm, 7 days a week. You can also send your request in writing to:

VillageCareMAX
 112 Charles Street,
 New York, NY 10014

Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period**.

You will also need to get prior authorization, if you are getting a service now, but need to get more of the care during an authorization period. This is called a **concurrent review**.

What happens after we get your service authorization request?

The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically

provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests

- Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- Fast track review: We will make a decision within 1 work day of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-469-6292 (TTY: 711) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint

about the review time with the New York State Department of Health by calling 1-866-712-7197.

If you are not satisfied with our answer, you have the right to file an appeal with us. See the Appeal section later in this handbook.

If for some reason you do not hear from us on time it is the same as if we denied your service authorization request. If this happens, you have the right to request a State Fair Hearing. See the Fair Hearing section later in this handbook.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Timeframes for notice of other actions

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

What to do if you have a complaint about your Plan or want to appeal a decision about your care

As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether VillageCareMAX Medicare Total Advantage determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered by Medicare (e.g., chiropractic services), or Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the rules outlined in Chapter 9 Sections 3, 4, 5, 6, 10, 11 and Chapter 13 of VillageCareMAX Medicare Total Advantage's Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicare Part D prescription drugs (e.g. chiropractic services), you will follow the rules outlined in Chapter 9 Section 7 of VillageCareMAX Medicare Total Advantage's Evidence of Coverage.

VillageCareMAX Medicare Total Advantage will explain the complaints and appeals processes available to you depending on the complaint you have. Call member services at 1-800-469-6292 (TTY: 711) 8:00 am – 8:00 pm, 7 days a week to get more information on your rights and the options available to you.

There are no costs unless you have a spend-down

As part of the enrollment process, HRA reviews your financial status for Medicaid eligibility. HRA may determine that you must spend a portion of your monthly income in order to meet the maximum income eligibility amount for Medicaid. HRA will inform you and VillageCareMAX of the exact amount of "spend-down" owed by you to VillageCareMAX each month. In order to enroll and receive benefits from VillageCareMAX you must pay this amount to VillageCareMAX. We will mail you an invoice in the beginning of every month and let you know how much "spend down" you need to pay. The amount you owe is due at the end of that month. If you do not pay the "spend-down" amount within 30 days after the due date, VillageCareMAX may disenroll you from the plan.

If you have any questions regarding the Medicaid "spend-down", please contact HRA at:

Human Resources Administration Medical Assistance Program
Home Care Services Program
330 West 34th Street, Room 912 New York, NY 10001
1-212-630-1945

There are no other payments to VillageCareMAX

If you receive a bill from any health care provider for covered services, please inform Member Services so that we may investigate the reason for you being billed.

Can I Leave the Plan?

Yes. Enrollment is voluntary, and you can ask to leave the plan at any time, for any reason, by making the request verbally or in writing. If your disenrollment is due to a complaint or concern, please contact Member Services. We value your membership in VillageCareMAX and would appreciate an opportunity to address and resolve your dissatisfaction with the Plan.

VillageCareMAX must get approval or notification from both Medicare and Medicaid to disenroll you from VillageCareMAX Medicare Total Advantage:

- Medicare approves the disenrollment from Medicare Advantage (see Chapter 10 about the Medicare process)
- Medicaid approves your disenrollment from Medicaid Advantage Plus (MAP) program (read below about the Medicaid process).

Both steps must be completed so that you can be disenrolled from VillageCareMAX Medicare Total Advantage. As much as possible, VillageCareMAX will try to make the effective date of disenrollment the same from Medicare Advantage and MAP. However, in some cases, Medicare may approve you for an earlier disenrollment date before Medicaid. In this case, VillageCareMAX will continue to provide Medicaid-covered benefits until Medicaid approves your disenrollment.

Medicaid Disenrollment Process

It could take up to six weeks to process your request, depending on when your request is received. Generally, if you notify VillageCareMAX that you wish to disenroll by the 15th day of the month, your disenrollment will be effective on the first day of the next month. If you notify us after the 15th day of the month, your disenrollment will not be effective until the following month. For example, if you make a disenrollment request between January 1 and January 15, your disenrollment may take effect of February 1. If you make your request between January 16 and January 31, your disenrollment will take effect on March 1.

You will receive written notification of the date of your disenrollment. VillageCareMAX will continue to provide or arrange for the provision of covered services to you until the effective date of your disenrollment. If you disenroll and need to continue to get long-term care services, you will need to enroll in a Managed Long Term Care Plan (MLTCP), Fully Integrated Duals Advantage (FIDA) Plan or another Medicaid Advantage Plus (MAP) program. Contact the New York State's Enrollment Broker at 1-888-401-6582 (TTY: 1-888-329-1541) for assistance in transferring to another plan. VillageCareMAX will also assist with transferring you to another plan as needed.

There are situations when we may have to disenroll a member. This is called an involuntary disenrollment. Disenrollment may not be based on deterioration, worsening of your health or cost of your covered services.

We must disenroll you from the Plan if:

- You move out of the service area.
- You leave the service area for more than 90 consecutive days.
- You are admitted to a skilled nursing facility (nursing home) and are not eligible for Institutional Medicaid.
- Your Medicaid is terminated.
- You no longer demonstrate a functional or clinical need for the community based long term care services of the plan.
You are no longer in need of nursing home level of care as determined by the last assessment using the tool required by the Department of Health.
- You join a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices of Mental Health, People with Developmental Disabilities, or Alcoholism and Substance Abuse Services.
- You are no longer enrolled in VillageCareMAX Medicare Total Advantage for your Medicare coverage.

- You expired.

You may be disenrolled from the Plan if:

- You or others in your home exhibit abusive, disruptive or uncooperative behavior to such a degree as to jeopardize the provision of care.
- You have failed to pay your spend-down within 30 days.
- You or your family provide the program with false information or engage in fraudulent conduct.
- You knowingly fail to complete and submit requested documentation.

Your Care Manager will work with you to attempt to resolve these issues. If the issues are not resolved, then VillageCareMAX will notify the State's Enrollment Broker – New York Medicaid Choice – of the request for disenrollment. NYMC must agree with any involuntary disenrollment, and will send written notification of such to you. VillageCareMAX will continue to provide or arrange for the provision of the covered services to you until the effective date of your disenrollment. Program personnel will assist you with arrangements for future services from another provider. In order to prevent a lapse in delivery of services to you, services from the new provider will be effective on the date of disenrollment from VillageCareMAX.

Re-Enrollment

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, for any reason, you may complete a new application for re-enrollment at any time if your issue for disenrollment has been resolved.

What are my Rights and Responsibilities?

- ✓ You have the Right to receive medically necessary care.
- ✓ You have the Right to timely access to care and services.
- ✓ You have the Right to privacy about your medical record and when you get treatment.
- ✓ You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- ✓ You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- ✓ You have the Right to get information necessary to give informed consent before the start of treatment.
- ✓ You have the Right to be treated with respect and dignity.

- ✓ You have the Right to get a copy of your medical records and ask that the records be amended and corrected.
- ✓ You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- ✓ You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- ✓ You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- ✓ You have the Right to be advised of where, when and how to get the services you need from VillageCareMAX including how you can get benefits from out-of-network providers.
- ✓ You have the Right to complain to the New York State Department of Health or your local Department of Social Services, the right to use the New York State Fair Hearing System and the right to use the New York State External Appeals Program.
- ✓ You have the Right to appoint someone to speak for you about your care and treatment.
- ✓ You have the Right to make advance directives and plans about your care. (You will receive written information on advance directives including a description of the applicable State Law).
- ✓ You have the Right to receive assistance in completing a health care proxy form and to ensure your advanced directives may be carried out.
- ✓ You have the Right to begin disenrollment from VillageCareMAX at any time.
- ✓ You have the Right to assist in the development and evaluation of new and existing programs and policies.
- ✓ You have the Right to choose your primary care physician.
- ✓ You have the Right to seek assistance from the Participant Ombudsman program.

As a Member of VillageCareMAX you have the following responsibilities:

- ✓ Accept services without regard to the race, color, religion, age, sex, national origin or disability of the caregiver.
- ✓ Obtain prior authorization for services and treatments provided by VillageCareMAX from your physician, nurse Care Manager and Member Services (emergency services do not require prior approval).
- ✓ When applicable, make payment to VillageCareMAX of any "spend-down" monies as

identified by the HRA.

- ✓ Keep appointments or notify the program if an appointment cannot be kept.
- ✓ Supply accurate and complete information to caregivers.
- ✓ Participate in the development and updating of your care plan.
- ✓ Request further information from your nurse Care Manager regarding anything you do not understand.
- ✓ Assist in developing and maintaining a safe environment.
- ✓ Comply with all requirements of VillageCareMAX as noted in the Member Handbook.
- ✓ Obtain services within the VillageCareMAX Network Provider list when necessary.
- ✓ Participate in questionnaires and/or surveys and focus groups to enhance our quality of service regarding this program.

You Will Be Provided With The Following Information Upon Your Request

- ✓ List of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of VillageCareMAX.
- ✓ The most recent annual certified financial statement of VillageCareMAX.
- ✓ Information relating to consumer complaints in regard to VillageCareMAX.
- ✓ Written description of the organizational arrangements for VillageCareMAX
- ✓ Description of VillageCareMAX's procedures with regard to protecting the confidentiality of medical records and other member information and ongoing process of the quality assurance program.
- ✓ Health practitioners' affiliations with hospitals.
- ✓ Description of criteria used when making decisions regarding approval or denial of services.
- ✓ Application procedures and minimum qualification requirements for health care providers to participate in VillageCareMAX.
- ✓ A copy of your VillageCareMAX program record, upon written request.

Participant Ombudsman Program

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide participants with free, confidential assistance on any long term care services.

These services include, but are not necessarily limited to:

- Provide pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
- Compile enrollee complaints and concerns about enrollment, access to services, and other related matters,
- Help you understand the fair hearing, grievance and appeal rights and processes within the health plan and at the State level, and assisting you through the process if needed/requested, including making requests of plans and providers for records, and
- Inform plans and providers about community-based resources and supports that can be linked with covered plan benefits.

ICAN is available Monday through Friday from 8:00 am to 8:00 pm and can be reached toll-free at 1-844-614-8800 (TTY: 711) or online at icannys.org. When ICAN contacts VillageCareMAX on your behalf, we will work with ICAN to help you.

Money Follows the Person (MFP) Program /Open Doors

This section will explain the services and supports that are available through *Money Follows the Person (MFP)/Open Doors*. *MFP/Open Doors* is a program that can help enrollees move from a nursing home back into their home or residence in the community. You may qualify for MFP if you:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk to you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about *MFP/Open Doors*, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Notice of Non-discrimination

VillageCareMAX complies with Federal civil rights laws. VillageCareMAX does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. VillageCareMAX does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

VillageCareMAX provides the following:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
 - ✓ Qualified sign language interpreters
 - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
 - ✓ Qualified interpreters
 - ✓ Information written in other languages

If you need these services, contact VillageCareMAX Member Services Department at 1-800-469-6292. For TTY/TDD services, call 711.

If you believe that VillageCareMAX has not given these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with VillageCareMAX by:

Mail:	Grievances Coordinator, VillageCareMAX, 112 Charles Street, New York, NY 10014
Phone:	1-800-469-6292, TTY 711
Fax:	347-226-5180
In person:	Grievances Coordinator, VillageCareMAX, 112 Charles Street, New York, NY 10014
Email:	complaints@villagecare.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights by:

Web:	Office of Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building Washington, D.C. 20201 Complaint forms are available at www.hhs.gov/ocr/office/file/index.html .
Phone:	1-800-368-1019, 800-537-7697 (TDD)

Handbook insert that includes changes to Service Authorizations, Actions, Appeals and Complaints

You have Medicare and get assistance from Medicaid. Information in this chapter covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will not use one process for your Medicare benefits and a different process for your Medicaid benefits. You will usually use one process for both. This is sometimes called an “integrated process” because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional **External Appeals** process. See page 292 for more information on the External Appeals process.

Section 1: Service Authorization Request (also known as Coverage Decision Request)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you must get approval for these treatments or services. You, your doctor, or designated representative may call Member Services at 1-800-469-6292 (TTY: 711) from 8:00 am to 8:00 pm, 7 days a week. You can also send your request in writing to:

VillageCareMAX
112 Charles Street,
New York, NY 10014

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period**.

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from VillageCareMAX Medicare Total Advantage before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved **before** you get them:

Service	Coverage Rules
Adult Day Health Care Provides care and services in a residential health care facility or approved extension site. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as Adult	You must get Adult Day Health Care from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the Adult Day Health Care provider. VillageCareMAX will assist

Service	Coverage Rules
<p>Adult Day Health Care (continued) leisure time activities that are a planned program of diverse and meaningful activities. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services.</p>	<p>your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX</p>
<p>Audiology/Hearing Aids not covered by Medicare Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.</p>	<p>You must get audiology/hearing aids from the VillageCareMAX Provider Network.</p> <p>Prior authorization may be required from VillageCareMAX.</p>
<p>Consumer Directed Personal Assistance This is a self-directed program where a member or a person acting on a member's behalf, known as a designated representative, directs and manages the member's personal care services, home health aide services or skilled nursing tasks. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping. This is provided by an aide chosen and directed by the member or a designated representative.</p>	<p>You must coordinate your consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Dental Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.</p>	<p>You must get dental services from the VillageCareMAX dental Provider Network provided by Healthplex.</p> <p>Prior authorization may be required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Durable Medical Equipment (DME) not covered by Medicare</p> <p>Durable medical equipment is made up of devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition. Durable medical equipment covered by Medicaid includes items such as tub stools, grab bars, medical/surgical supplies, and enteral formula that are not otherwise covered by Medicare.</p>	<p>You must get items from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the provider.</p> <p>VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX for certain items.</p>
<p>Home-Delivered Meals and/or Meals in a Group Setting</p> <p>Services include meals that are delivered at home or in a group setting for individuals who are unable to prepare meals or unable to get assistance with meal preparation.</p>	<p>You must get home delivered or congregate meals from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Home Health Care Services Not Covered by Medicare</p> <p>Medicaid-covered home health services include the provision of skilled services not covered by Medicare. VillageCareMAX Medicare Total Advantage coordinates the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health.</p>	<p>You must get home health care services from the VillageCareMAX Provider Network. Services are based on a plan of care that your physician approves, and all services are provided in your home.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit</p> <p>Services include mental health care services that require a hospital stay. Medicaid covers the deductible and cost of the days in excess of the Medicare 190-day lifetime limit. There is no limit to the number of days covered by the plan each hospital stay. You are covered for up to 365 days per year (366 in a leap year) with no deductible or copayment.</p>	<p>You must get inpatient mental health services from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Medical Social Services</p> <p>These services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of your needs in your home when such services are performed by a qualified social worker. Medical social services will assist you with concerns related to your illness, finances, housing or environment.</p>	<p>You must get Medical Social Services from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies</p> <p>Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and device and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, and administered for a specific purpose</p>	<p>These items may be covered by Medicare. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Non-emergency Transportation</p> <p>Non-Emergency Transportation is transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member's condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.</p>	<p>You must get non-emergency transportation from the VillageCareMAX Provider Network, and call VillageCareMAX two days in advance to schedule transportation.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Nursing Home Care not covered by Medicare</p> <p>Medicaid-covered care provided in a Skilled Nursing Facility</p>	<p>Your doctor will need to provide signed written orders to the nursing home. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network provider.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Nutrition Services/Counseling</p> <p>Services include the assessment of nutritional needs for your physical and medical needs and environmental conditions. These include the provision of nutrition education and counseling to meet your therapeutic needs and development of a nutritional treatment plan.</p>	<p>You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Optometry/Eyeglasses</p> <p>Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.</p>	<p>You must get optometry services and eyeglasses from the VillageCareMAX Provider Network.</p> <p>Prior authorization may be required from VillageCareMAX.</p>
<p>Outpatient Mental Health & Substance Abuse</p> <p>Services to treat mental health and substance abuse conditions in an outpatient setting.</p>	<p>You must get outpatient mental health & substance abuse services from the VillageCareMAX Provider Network.</p> <p>You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period.</p> <p>Prior authorization is only required for out-of-network service requests, electroconvulsive therapy (ECT), and neuropsychological testing.</p>
<p>Personal Care</p> <p>Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks.</p>	<p>You must get personal care from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the agency providing care. VillageCareMAX will assist</p>

Service	Coverage Rules
Personal Care (continued)	<p>your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
Personal Emergency Response Systems (PERS) PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	<p>You must get PERS from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home <p>Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p> <p>Occupational therapy is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p> <p>Speech-language therapy is rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.</p>	<p>VillageCareMAX will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.</p> <p>Your doctor will need to provide signed written orders to the Rehabilitation Therapist. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.</p> <p>You can get services from or outside of the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
Podiatry services not covered by Medicare Podiatry means services by a podiatrist, which must include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.	<p>You can get podiatry services from or outside of the VillageCareMAX Provider Network.</p>

Service	Coverage Rules
<p>Private Duty Nursing</p> <p>Private Duty Nursing are medically necessary services provided at enrollee’s permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).</p>	<p>You must get private duty nursing services from the VillageCareMAX Provider Network and requires a doctor’s order.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Prosthetics, Orthotics and Orthopedic Footwear</p> <p>Prosthetic appliances and devices are appliances and devices that replace any missing part of the body.</p> <p>Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Orthopedic footwear includes shoes, shoe modifications or shoe additions that are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot. Orthopedic footwear also is used to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p>	<p>You must get items from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the provider.</p> <p>VillageCareMAX will assist your provider in obtaining doctor’s orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Respiratory Therapy</p> <p>The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.</p>	<p>You must get respiratory therapy from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the therapist providing care.</p> <p>VillageCareMAX will assist your provider in obtaining doctor’s orders if needed.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Social and Environmental Supports</p> <p>Social and environmental supports are services and items that maintain the medical needs of the member and include the following: home maintenance tasks, homemaker/chore services, housing improvement and respite care.</p>	<p>You must get social and Environmental supports from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<p>Social Day Care</p> <p>Social day care is a structured program that provides functionally impaired individuals with socialization, supervision, monitoring and nutrition in a protective setting during any part of the day. Additional services may include personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.</p>	<p>You must get Social day care from the VillageCareMAX Provider Network.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Telehealth</p> <p>Telehealth is the use of technologies to deliver or support clinical health care for covered services from a distance to reduce the need for in-office visits. The services include live video between a member and a provider; transmission of recorded health history through a secure electronic communications system; and use of mobile devices to provide supportive services.</p>	<p>Telehealth can be received to support covered services only.</p> <p>Prior authorization is required from VillageCareMAX.</p>
<p>Veteran's Home Services</p> <p>If you are a veteran, spouse of a veteran, or Gold Star parent in need of long term nursing home services, you may access Veteran's Home Services.</p>	<p>If VillageCareMAX does not have an accessible in-network veteran's home, the plan will authorize out-of-network services until member is transferred to another plan with an in-network veteran's home.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Concurrent Review

You can also ask VillageCareMAX Medicare Total Advantage get more of a service than you are getting now. This is called concurrent review.

Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request

The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called **clinical review criteria**, used to make the decision about medical necessity.

After we get your request, we will review it under either a **standard** or a **fast track** process. You or your provider can ask for a fast track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your request. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process

Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item or service unless we have agreed to use the fast track deadlines.

- A standard review for a prior authorization request means we will give you an answer within 3 work days of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 work day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.
- **We can take up to 14 more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should **not** take extra days, you can file a **“fast complaint.”** When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **If our** answer is yes to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

- **If our answer is no to part or all of what you asked for**, we will send you a written notice that explains why we said no. Section 2: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

If your health requires it, ask us to give you a **“fast service authorization.”**

- A fast review of a prior authorization request means we will give you an answer within 1 work day of when we have all the information we need but no later than **72 hours** from when you made your request to us.
- We can take **up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a “fast complaint”** (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal.

To get a fast service authorization, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)
2. Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

If your provider tells us that your health requires a “fast service authorization,” we will automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider’s support, we will decide whether your health requires that we give you a fast service authorization.

If we decide that your medical condition does not meet the requirements for a fast service authorization, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard service authorization instead of the fast service authorization you asked

for. (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

If our answer is no to part or all of what you asked for, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If we are changing a service you are already getting

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are checking care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF)** services is ending. For more information about these rights, refer to Chapter 9 of the VillageCareMAX Medicare Total Advantage Evidence of Coverage.

What To Do If You Want To Appeal A Decision About Your Care

If we say no to your request for coverage for a medical item or service, you decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- VillageCareMAX Medicare Total Advantage can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-800-469-6292 (TTY: 711) to get more information on your rights and the options available to you.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 2: Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

You can file a Level 1 Appeal:

When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Different reviewers handle your appeal than the ones who made the original unfavorable decision. When we complete the review, we will give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **“fast appeal.”**
 - The requirements and procedures for getting a “fast appeal” are the same as for getting a “fast track service authorization.” To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)
 - If your provider tells us that your health requires a “fast appeal,” we will give you a fast appeal.

- If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.
- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at 1-800-469-6292 (TTY: 711) if you need help filing a Level 1 Appeal.
 - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an “Appointment of Representative” form, or write and sign a letter naming your representative.
 - To get an “Appointment of Representative” form, call Member Services and ask for the form. You can also get the form on the Medicare website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at <https://www.villagecaremax.org>. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
 - You can write a letter and send it to us. (Your or the person named in the letter as your representative can send us the letter.)
- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.
- You can make the Level 1 Appeal by phone or in writing

Continuing your service or item while appealing a decision about your care

If we told you we were going to stop, suspend, or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.
- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- **Note:** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at 1-800-469-6292 (TTY: 711) if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will **automatically** send your case on to the next level of the appeals process.

Timeframes for a “standard” appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request **within 30 calendar days** after we get your appeal if your appeal is about coverage for services you have not gotten yet.
- We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
 - For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
 - An independent outside organization will review it.

- We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal**. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a “fast” appeal

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

If our answer is yes to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours after we get your appeal.

If our answer is no to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don’t agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the “**Integrated Administrative Hearing Office**” or “**Hearing Office**,” reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.
- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 3: Level 2 Appeals.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 3: Level 2 Appeals

Information in this section applies to **all** of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

If we say **No** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency.** It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a free copy of your case file.**
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 90 calendar days** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 288 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you its decision in writing and explain the reasons for it.

- If the Hearing Office says **yes** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office’s decision.**

- If the Hearing Office says **no** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”)

If the Hearing Office says no to part or all of your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.
- The decision you get from the Medicare Appeals Council related to **Medicaid** benefits will be **final**.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 4: External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**.

You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- not medically necessary or
- experimental or investigational or
- not different from care you can get in the plan’s network or
- available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in the plan’s benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan’s Final Adverse Determination; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**

- You and the plan may agree to skip the plan’s appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the plan’s Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan’s appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services at 1-800-469-6292 (TTY: 711) if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services’ website at www.dfs.ny.gov .
- Contact the health plan at 1-800-469-6292 (TTY: 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 5: What To Do If You Have A Complaint About Our Plan

Information in this section applies to **all** of your Medicare and Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at 1-800-469-6292 (TTY: 711) or write to Member Services. **The formal name for “making a complaint” is “filing a grievance.”**

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You can call us at 1-800-469-6292 (TTY: 711), during the hours of 8:00 am to 8:00 pm, 7 days a week
- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Send us your complaint in writing using the address listed in Chapter 2, Section 2 called: *How to contact us when you are making a complaint about your medical care.*
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **We answer most complaints in 30 calendar days.**
- If you are making a complaint because we denied your request for a “fast service authorization” or a “fast appeal,” **we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:
 - If you asked us to give you a “fast service authorization” or a “fast appeal” and we said we will not.
 - If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
 - When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
 - When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

If you disagree with a decision we made about your complaint about your Medicaid benefits, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- You must make the complaint appeal in writing.
 - If you make an appeal by phone, you must follow it up in writing.
 - After your call, we will send you a form that summarizes your phone appeal.
 - If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal;
- How to contact this person;
- If we need more information.

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within 30 work days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale, if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.