

**January 1 – December 31, 2023**

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

**For questions about this document, please contact Member Services at 1-800-469-6292. (TTY users should call 711). Hours are 7 days a week, from 8:00 am to 8:00 pm.**

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

This document is available for free in Spanish and Chinese.

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

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

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

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

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

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## Multi-Language Insert

### Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-469-6292. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-469-6292. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-469-6292。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-469-6292。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-469-6292. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-469-6292. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-469-6292 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-469-6292. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-469-6292번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-469-6292. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-469-6292. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-469-6292 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-469-6292. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-469-6292. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-469-6292. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-469-6292. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-469-6292 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

## **2023 Evidence of Coverage**

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# CHAPTER 1:

## *Getting started as a member*



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**SECTION 1 Introduction**

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<b>Section 1.1</b>	<b>You are enrolled in VillageCareMAX Medicare Total Advantage, which is a specialized Medicare Advantage Plan (Special Needs Plan)</b>
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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 health care and your prescription drug coverage through our plan, VillageCareMAX Medicare Total Advantage. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

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 for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Medicaid may also provide other benefits to you by covering health care services that are not usually covered under Medicare. 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 health care coverage, including your prescription drug coverage

**Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

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

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

The word “coverage” and “covered services” refers to the medical care and 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* document.

If you are confused, concerned or just have a question, please contact Member Services.

**Section 1.3      Legal information about the *Evidence of Coverage***

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, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of VillageCareMAX Medicare Total Advantage after December 31, 2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

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

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

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**Section 2.1      Your eligibility requirements**

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

**Chapter 1 Getting started as a member**

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

**Special eligibility requirements for our plan**

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Medicaid. 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 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).

<b>Section 2.2</b>	<b>What is Medicaid?</b>
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Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

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.

**Chapter 1 Getting started as a member**

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**Section 2.3      Here is the plan service area for VillageCareMAX Medicare Total Advantage**

*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), Queens, Nassau, Richmond (Staten Island) and Westchester.

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

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

**Section 2.4      U.S. Citizen or Lawful Presence**

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify *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.

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**SECTION 3      Important membership materials you will receive**

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**Section 3.1      Your plan membership card**


While you are a member of our plan, you must use your membership card whenever you get 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:

## Chapter 1 Getting started as a member

### SAMPLE

Front of Member Identification Card

**VILLAGECAREMAX**  
 VillageCareMAX Medicare Total Advantage (HMO D-SNP)

<b>Member Name:</b> <FName> <LName>	
<b>Member ID:</b> <Subscriber ID #>	
<b>Health Plan (80840):</b> 7538162273	
<b>Effective Date:</b> <Enrollment Date>	
<b>PCP Name:</b> <PCP Name>	<b>RxBin:</b> 015574
<b>PCP Phone:</b> <PCP Phone>	<b>RxPCN:</b> ASPROD1
	<b>RxGRP:</b> VCM02

**Copays:** \$0

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.

<b>Member Services:</b>	1-800-469-6292 (TTY: 711)
<b>Mental Health &amp; Addiction:</b>	1-866-599-1481 (TTY: 711)
<b>Prescription Drugs:</b>	1-888-807-6806 (TTY: 711)
<b>Vision:</b>	1-800-879-6901 (TTY: 711)
<b>Dental:</b>	1-888-442-8878 (TTY: 1-877-855-8039)
<b>Transportation:</b>	1-855-205-2000 (TTY: 711)
<b>Website:</b>	www.villagecaremax.org

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**Provider Services:** 1-855-769-2500  
**Medical Claims:** ILS – VillageCareMAX, 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 Medicare approved clinical research studies also called clinical trials.

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

## Section 3.2 Provider and Pharmacy Directory

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

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

- *Out-of-network/non-contracted providers are under no obligation to treat Plan 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.*

The Provider and Pharmacy Directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You

**Chapter 1 Getting started as a member**

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can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

The most recent list of providers and suppliers is available on our website at [www.villagecaremax.org](http://www.villagecaremax.org).

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Member Services. Both Member Services and the website can give you the most up-to-date information about our network providers.

<b>Section 3.4</b>	<b>The plan's <i>List of Covered Drugs (Formulary)</i></b>
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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*. 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.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([www.villagecaremax.org](http://www.villagecaremax.org)) or call Member Services.

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<b>SECTION 4</b>	<b>Your monthly costs for VillageCareMAX Medicare Total Advantage</b>
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Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

<b>Section 4.1</b>	<b>Plan premium</b>
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You do not pay a separate monthly plan premium for *VillageCareMAX Medicare Total Advantage* because you receive full extra help.

## **Section 4.2      Monthly Medicare Part B Premium**

### **Many members are required to pay other Medicare premiums**

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *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.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

## **Section 4.4      Part D Late Enrollment Penalty**

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

When you first enroll in *VillageCareMAX Medicare Total Advantage*, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty.

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

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.

**Chapter 1 Getting started as a member**

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- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is \$32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$32.74, which equals \$4.58. This rounds to \$4.60. This amount would be **added to the monthly premium for someone with a Part D late enrollment penalty.**

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

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

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

<b>Section 4.5</b>	<b>Income Related Monthly Adjustment Amount</b>
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Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.



**Chapter 1 Getting started as a member**

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If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

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

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**SECTION 5 Please keep your plan membership record up to date**

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<b>Section 5.1 Can we change your monthly plan premium during the year?</b>
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**No.** We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

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

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

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

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**SECTION 6 Keeping your plan membership record up to date**

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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.

**Chapter 1 Getting started as a member**

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**Let us know about these changes:**

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

If any of this information changes, please let us know by calling Member Services.

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.

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**SECTION 7      How other insurance works with our plan**

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**Other insurance**

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

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

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

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

- If you have retiree coverage, Medicare pays first.

**Chapter 1 Getting started as a member**

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

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

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

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

# CHAPTER 2:

*Important phone numbers  
and resources*

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

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### **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.

<b>Method</b>	<b>Member Services – Contact Information</b>
<b>CALL</b>	1-800-469-6292 Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	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. Available seven days a week from 8:00 am to 8:00 pm
<b>FAX</b>	1-212-337-5711 1-347-226-5180
<b>WRITE</b>	VillageCareMAX 112 Charles Street, New York, NY 10014
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

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

<b>Method</b>	<b>Coverage Decisions and Appeals for Medical Care – Contact Information</b>
<b>CALL</b>	1-800-469-6292 Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	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. Available seven days a week from 8:00 am to 8:00 pm
<b>FAX</b>	1-212-337-5711 ( <i>Coverage Decisions</i> ) 1-347-226-5180 ( <i>Appeals</i> )
<b>WRITE</b>	VillageCareMAX 112 Charles Street, New York, NY 10014
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

<b>Method</b>	<b>Coverage Decisions and Appeals for Medical Care – Contact Information</b>
<b>Method</b>	<b>Coverage Decisions for for Part D prescription drugs – Contact Information</b>
<b>CALL</b>	1-888-807-6806 Calls to this number are free. Available 24 hours a day, 7 days a week.
<b>TTY</b>	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. Available 24 hours a day, 7 days a week.
<b>FAX</b>	1-858-790-7100
<b>WRITE</b>	MedImpact Healthcare Systems, Inc. Attention: PA Department, 10181 Scripps Gateway Ct, San Diego, CA 92131
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

Method	Appeals for Part D prescription drugs – Contact Information
<b>CALL</b>	1-888-807-6806 Calls to this number are free. Available 24 hours a day, 7 days a week.
<b>TTY</b>	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. Available 24 hours a day, 7 days a week.
<b>FAX</b>	1-858-790-6060
<b>WRITE</b>	MedImpact Healthcare Systems, Inc. Attention: Appeals/Grievances Department, 10181 Scripps Gateway Ct, San Diego, CA 92131
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

### **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 or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).



**Chapter 2 Important phone numbers and resources**

<b>Method</b>	<b>Complaints about Medical Care – Contact Information</b>
<b>CALL</b>	1-800-469-6292 Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm.
<b>TTY</b>	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. Available seven days a week from 8:00 am to 8:00 pm.
<b>FAX</b>	1-347-226-5180
<b>WRITE</b>	VillageCareMAX 112 Charles Street, New York, NY 10014
<b>MEDICARE WEBSITE</b>	You can submit a complaint about <i>VillageCareMAX Medicare Total Advantage</i> directly to Medicare. To submit an online complaint to Medicare go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a> .

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of 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.

<b>Method</b>	<b>Payment Requests – Contact Information</b>
<b>CALL</b>	1-800-469-6262 Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm
<b>TTY</b>	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. Available seven days a week from 8:00 am to 8:00 pm.
<b>FAX</b>	212-337-5711
<b>WRITE</b>	VillageCareMAX 112 Charles Street New York NY 10014
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

<b>Method</b>	<b>Prescription Drugs Payment Requests – Contact Information</b>
<b>CALL</b>	1-888-807-6806 Calls to this number are free. Available 24 hours a day, 7 days a week
<b>TTY</b>	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. Available 24 hours a day, 7 days a week.
<b>WRITE</b>	MedImpact Healthcare Systems, Inc. P.O. Box 509108 San Diego, CA 92150-9010
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

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

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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.

<b>Method</b>	<b>Medicare – Contact Information</b>
<b>CALL</b>	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. Available 24 hours a day, 7 days a week.
<b>TTY</b>	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.
<b>WEBSITE</b>	<u><a href="http://www.medicare.gov">www.medicare.gov</a></u> This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none"><li>• <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information.</li><li>• <b>Medicare Plan Finder:</b> 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.</li></ul>

**Chapter 2 Important phone numbers and resources**

Method	Medicare – Contact Information
<b>WEBSITE (continued)</b>	<p>You can also use the website to tell Medicare about any complaints you have about VillageCareMAX Medicare Total Advantage:</p> <ul style="list-style-type: none"> <li>• <b>Tell Medicare about your complaint:</b> You can submit a complaint about VillageCareMAX Medicare Total Advantage directly to Medicare. To submit a complaint to Medicare, go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</li> </ul> <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 and review the information with 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>

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

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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 an independent (not connected with any insurance company or health plan) 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 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 with Medicare questions or problems and 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](http://www.medicare.gov)
- Click on “**Talk to Someone**” in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

<b>Method</b>	<b>Health Insurance Information, Counseling and Assistance Program (HIICAP)– Contact Information</b>
<b>CALL</b>	1-800-701-0501 Calls to this number are free. Available Monday through Friday, 9:00 am to 4:00 pm
<b>TTY</b>	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. Available Monday through Friday, 9:00 am to 4:00 pm
<b>WRITE</b>	Health Insurance Information, Counseling and Assistance Program (HIICAP) 2 Lafayette Street, 9 <sup>th</sup> Floor New York, NY 10007-1392
<b>WEBSITE</b>	<a href="https://aging.ny.gov/health-insurance-information-counseling-and-assistance">https://aging.ny.gov/health-insurance-information-counseling-and-assistance</a>

**SECTION 4 Quality Improvement Organization**

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 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.

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 (New York's Quality Improvement Organization) – Contact Information
<b>CALL</b>	1-866-815-5440 Calls to this number are free. Available Monday through Friday from 9:00 am to 9:00 pm, and Saturday through Sunday from 11:00 am to 3:00 pm.
<b>TTY</b>	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free.
<b>WRITE</b>	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
<b>WEBSITE</b>	<a href="https://www.livantaqio.com/en/states/new_york">https://www.livantaqio.com/en/states/new_york</a>

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## **SECTION 5      Social Security**

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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.

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

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## **SECTION 6      Medicaid**

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

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

An individual who qualifies for Medicare and Medicaid coverage is referred to as dual eligible. *VillageCareMAX Medicare Total Advantage* is a Dual Eligible Special Needs Plan that covers both your Medicare and Medicaid benefits.

If you have questions about the assistance you get from Medicaid, contact the New York State Department of Health Medicaid Helpline:

<b>Method</b>	<b>New York State Department of Health Medicaid Helpline – Contact Information</b>
<b>CALL</b>	1-800-541-2831 Calls to this number are free. Available Monday through Friday, 8:00 am to 5:00 pm, and Saturday from 9:00 am to 1:00 pm.
<b>TTY</b>	1-800-662-1220 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available Monday through Friday, 8:00 am to 5:00 pm, and Saturday from 9:00 am to 1:00 pm.
<b>WRITE</b>	<a href="mailto:Medicaid@health.ny.gov">Medicaid@health.ny.gov</a>
<b>WEBSITE</b>	<a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>



The Independent Consumer Advocacy Network (ICAN) helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

<b>Method</b>	<b>Independent Consumer Advocacy Network (ICAN) – Contact Information</b>
<b>CALL</b>	1-844-614-8800 Calls to this number are free Available Monday through Friday from 9:00 am to 5:00 pm
<b>TTY</b>	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 Available Monday through Friday from 9:00 am to 5:00 pm
<b>WRITE</b>	Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 633 Third Ave, 10 <sup>th</sup> Floor New York NY 10017
<b>WEBSITE</b>	<a href="http://www.icannys.org">www.icannys.org</a>

The 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	Office of Long Term Care Ombudsman Program – Contact Information
<b>CALL</b>	1-855-582-6769 Calls to this number are free Available: 9:00 am to 5:00 pm, Monday through Friday
<b>WRITE</b>	Long Term Care Ombudsman Program Two Empire State Plaza Albany, New York NY 12223-1251
<b>WEBSITE</b>	<a href="http://www.ltcombudsman.ny.gov">www.ltcombudsman.ny.gov</a>

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

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The Medicare.gov website (<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/6-ways-to-get-help-with-prescription-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

### **Medicare’s “Extra Help” Program**

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

If you have questions about “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 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 a process for you to either request assistance in

**Chapter 2 Important phone numbers and resources**

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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 document 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.

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. 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 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 on the ADAP formulary qualify for prescription cost-sharing assistance through the New York State HIV Uninsured Care Programs. **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

**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 Elderly Pharmaceutical Insurance Coverage (EPIC).

<b>Method</b>	<b>Elderly Pharmaceutical Insurance Coverage (EPIC) (New York's State Pharmaceutical Assistance Program) – Contact Information</b>
<b>CALL</b>	1-800-332-3742 Calls to this number are free Available Monday through Friday from 8:30am to 5:00pm
<b>TTY</b>	1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free Available Monday through Friday 8:30am to 5:00pm
<b>WRITE</b>	EPIC P.O. Box 15018 Albany, NY 12212-5018
<b>WEBSITE</b>	<a href="http://www.health.ny.gov/health_care/epic">www.health.ny.gov/health_care/epic</a>

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## **SECTION 8      How to contact the Railroad Retirement Board**

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The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

**Chapter 2 Important phone numbers and resources**

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<b>Method</b>	<b>Railroad Retirement Board – Contact Information</b>
<b>CALL</b>	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 24 hours a day, including weekends and holidays.
<b>TTY</b>	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.
<b>WEBSITE</b>	<a href="http://rrb.gov/">rrb.gov/</a>

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

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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, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) 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.

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 for your medical and  
other covered services*

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

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

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

<b>Section 1.1      What are “network providers” and “covered services”?</b>
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- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

<b>Section 1.2      Basic rules for getting your medical care and other services covered by the plan</b>
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As a Medicare health plan, VillageCareMAX Medicare Total Advantage must cover all services covered by Original Medicare 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 document).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Chapter 3 Using the plan for your medical and other covered services**

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- **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).
  - In most situations, our plan must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You must get prior authorization from the plan prior to seeking care. 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 or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.



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

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<b>Section 2.1</b>	<b>You must choose a Primary Care Provider (PCP) to provide and oversee your care</b>
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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 routine medical care. Your PCP will provide care, monitor your health, and help coordinate your services. You must choose a network provider to be your PCP when you become a member of our plan.

- *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.

- *Explain the role of a PCP in your 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.

- *What is the role of the PCP in coordinating covered services?*

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.

- *What is the role of the PCP in making decisions about or obtaining prior authorization (PA), if applicable?*

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](http://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 document). 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

**Chapter 3 Using the plan for your medical and other covered services**

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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 document). 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.

If you selected an in-network PCP, VillageCareMAX will let you know if your PCP leaves the network, and will help you choose another PCP. 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.

<b>Section 2.2</b>	<b>What kinds of medical care and other services can you get without a referral from your PCP?</b>
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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 are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

<b>Section 2.3</b>	<b>How to get care from specialists and other network providers</b>
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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

Prior authorization may be required for certain services and drugs. This means that you will need approval in advance before you can get these benefits. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary. You or your provider can request prior authorization from the plan by phone or in writing. The plan will review your request and make a decision if it is medically necessary to cover the service or drug. You can see any provider authorized by the plan. A referral is not required from your PCP.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is required.

**Chapter 3 Using the plan for your medical and other covered services**

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- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

<b>Section 2.4</b>	<b>How to get care from out-of-network providers</b>
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You must use network providers to get covered services except for emergency care, urgently needed care or out-of-area 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.

- *Out-of-network/non-contracted providers are under no obligation to treat Plan 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.*

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<b>SECTION 3</b>	<b>How to get services when you have an emergency or urgent need for care or during a disaster</b>
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<b>Section 3.1</b>	<b>Getting care if you have a medical emergency</b>
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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 your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a

**Chapter 3 Using the plan for your medical and other covered services**

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referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. The plan also covers Worldwide Emergency/Urgent Care when you travel outside of the United States and its territories.

- **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 document.

**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. Medicare does not provide coverage for emergency medical care outside the United States and its territories. However, our plan covers worldwide emergency care services outside the United States and its territories.

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

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

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

**What if it wasn't a medical emergency?**

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

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

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

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

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

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 or you can access our on call service when our offices are closed.

Medicare does not provide coverage for urgently needed care outside the United States and its territories.

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

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

**Section 3.3      Getting care during a disaster**

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

Please visit the following website: [www.villagecaremax.org](http://www.villagecaremax.org) for information on how to obtain needed care during a disaster.

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

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## **SECTION 4      What if you are billed directly for the full cost of your services?**

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<b>Section 4.1      You can ask us to pay for covered services</b>
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If you have paid more for covered services or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

<b>Section 4.2      What should you do if services are not covered by our plan?</b>
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VillageCareMAX Medicare Total Advantage covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services. Before paying for the cost of a service not covered by *VillageCareMAX Medicare Health Advantage*, you should check if the service is covered by Medicaid and can be accessed by using your Medicaid card.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. 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 \$8,300. Your out-of-pocket costs for covered medical benefits under Medicare will count towards your limit. Once you reach the limit, we will pay the full cost for covered medical benefits for the rest of the year. Most members get assistance from Medicaid, and 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.

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## **SECTION 5      How are your medical services covered when you are in a “clinical research study”?**

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<b>Section 5.1      What is a “clinical research study”?</b>
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A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

**Chapter 3 Using the plan for your medical and other covered services**

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

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.



**Chapter 3 Using the plan for your medical and other covered services**

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*Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and you would pay the \$20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

**Do you want to know more?**

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication “Medicare and Clinical Research Studies.” (The publication is available at: [www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://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.

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

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<b>Section 6.1</b>	<b>What is a religious non-medical health care institution?</b>
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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. This benefit is provided only for Part A inpatient services (non-medical health care services).

<b>Section 6.2</b>	<b>Receiving Care From a Religious Non-Medical Health Care Institution</b>
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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.

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 coverage for this benefit when medically necessary. Please see the Benefits Chart in Chapter 4 for more information.

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<b>SECTION 7</b>	<b>Rules for ownership of durable medical equipment</b>
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<b>Section 7.1</b>	<b>Will you own the durable medical equipment after making a certain number of payments under our plan?</b>
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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, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our

**Chapter 3 Using the plan for your medical and other covered services**

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plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call Member Services for more information.

**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. The payments made while enrolled in your plan do not count.

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

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

<b>Section 7.2</b>	<b>Rules for oxygen equipment, supplies, and maintenance</b>
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**What oxygen benefits are you entitled to?**

If you qualify for Medicare oxygen equipment coverage 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.

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

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

# CHAPTER 4:

## *Medical Benefits Chart (what is covered)*

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## **SECTION 1      Understanding covered services**

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This chapter provides a Medical Benefits Chart that lists your covered services 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.

<b>Section 1.1      You pay nothing for your covered services</b>
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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.)

<b>Section 1.2      What is the most you will pay for Medicare Part A and Part B covered medical services?</b>
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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 on the amount 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 (MOOP) amount for medical services. For calendar year 2023 this amount is \$8,300.

The amounts you pay for copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$8,300, 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).

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## **SECTION 2      Use the *Medical Benefits Chart* to find out what is covered**

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<b>Section 2.1      Your medical benefits as a member of the plan</b>
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The Medical Benefits Chart on the following pages lists the services *VillageCareMAX Medicare Total Advantage* covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.

- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked 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. Medicaid also covers services Medicare does not cover, like long-term care, over-the-counter drugs, home and community-based services, and other Medicaid-only services
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at [www.medicare.gov](http://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. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- *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 and items. If a benefit is also covered by Medicaid, a reference is made in the chart. A list of Medicaid-covered services and items are in Chapter 13 of this document.
- 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. However, during this period, we will not pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lose your Medicaid eligibility. The amount you pay for Medicare covered services may increase 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.

#### Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke, Osteoporosis; Inflammatory disorders; Eye disorders; Gastrointestinal disorders
  - You must have one or more these chronic conditions, require intense care coordination, and at a high risk for hospitalization or other adverse health outcomes. In addition, you must get care management services. Upon enrollment, VillageCareMAX will help determine if you meet the criteria and eligible to receive these benefits
- Please go to the “Special Supplemental Benefits for the Chronically Ill” row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.





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
<b>Abdominal aortic aneurysm screening</b> 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.



Services that are covered for you	What you must pay when you get these services
<p><b>Acupuncture for chronic low back pain*</b></p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> <li>• Lasting 12 weeks or longer;</li> <li>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);</li> <li>• not associated with surgery; and</li> <li>• not associated with pregnancy.</li> </ul> <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"> <li>• 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,</li> <li>• 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.</li> </ul> <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>There is no coinsurance, copayment, or deductible for members eligible for acupuncture for chronic low back pain services.</p> <p>*Prior Authorization is required from VillageCareMAX is required for Acupuncture for chronic low back pain</p>




Services that are covered for you	What you must pay when you get these services
<p><b>Acupuncture (above Medicare coverage)*</b></p> <ul style="list-style-type: none"> <li>You are covered for up to 50 visits per year with a maximum of 5 visits per month (up to \$80 limit per visit).</li> <li>Services must be provided by a certified and licensed provider in the VillageCareMAX network.</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare covered acupuncture visits.</p> <p>*Prior authorization may be required for certain services.</p>
<p><b>Ambulance services*</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare covered ambulances services.</p> <p>*Prior Authorization is required from VillageCareMAX for non-emergency ambulance transportation</p>
<p> <b>Annual wellness visit</b></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><b>Note:</b> 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> <b>Bone mass measurement</b></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>

Services that are covered for you	What you must pay when you get these services
 <b>Breast cancer screening (mammograms)</b> Covered services include: <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	There is no coinsurance, copayment, or deductible for covered screening mammograms.
<b>Cardiac rehabilitation services*</b> 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.	There is no coinsurance, copayment, or deductible for Medicare covered <ul style="list-style-type: none"> <li>• Cardiac rehabilitation services, and</li> <li>• Intensive cardiac rehabilitation services</li> </ul> <p>*Prior Authorization is required from VillageCareMAX for Cardiac rehabilitation services.</p>
 <b>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</b> We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 <b>Cardiovascular disease testing</b> Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months)	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.



Services that are covered for you	What you must pay when you get these services
 <b>Cervical and vaginal cancer screening</b> Covered services include: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>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</li> </ul>	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
<b>Chiropractic services*</b> Covered services include: <ul style="list-style-type: none"> <li>We cover only manual manipulation of the spine to correct subluxation</li> </ul>	There is no coinsurance, copayment, or deductible for Medicare covered chiropractic services.  *Prior Authorization is required from VillageCareMAX for Cardiac rehabilitation services.
 <b>Colorectal cancer screening</b> For people 50 and older, the following are covered: <ul style="list-style-type: none"> <li>Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> </ul> One of the following every 12 months: <ul style="list-style-type: none"> <li>Guaiaac-based fecal occult blood test (gFOBT)</li> <li>Fecal immunochemical test (FIT)</li> </ul> DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> <li>Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> For people not at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> <li>Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li> </ul>	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

Services that are covered for you	What you must pay when you get these services
<p><b>Dental services*</b></p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.</p> <p>Non-routine dental care covered by Original Medicare to treat illness or injury when you are in a hospital and it is medically necessary.</p> <p><i>The plan also covers Medicaid-covered dental services. See Chapter 13 for more information.</i></p>	<p>There is no coinsurance, copayment, or deductible for dental services</p> <p>*Prior Authorization may be required from Liberty Dental (dental vendor)</p>
<p><b>Additional dental benefits covered by VillageCareMAX*</b></p> <ul style="list-style-type: none"> <li>You are covered for up to \$2,000 (<b>\$500 per quarter</b>) per year for additional comprehensive dental services not covered by Medicaid such as non-routine care, extractions, fillings, implants, dentures, crowns, bridges, root canal and oral surgery.</li> <li>This benefit is limited to the dental procedure codes covered by the plan. Unused amounts from the quarterly limit carry over to the next quarter and must be used by December 31, 2023.</li> </ul>	
<p> <b>Depression screening</b></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> <b>Diabetes screening</b></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>

Services that are covered for you	What you must pay when you get these services
<p> <b>Diabetes self-management training, diabetic services and supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Diabetes self-management training is covered under certain conditions.</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered services:</p> <ul style="list-style-type: none"> <li>• Diabetic monitoring supplies</li> <li>• Diabetic therapeutic shoes or inserts.</li> <li>• Diabetes self-management training services.</li> </ul>
<p><b>Durable medical equipment (DME) and related supplies*</b></p> <p>(For a definition of “durable medical equipment,” see Chapter 12 as well as Chapter 3, Section 7 of this document.)</p> <p>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.</p> <p>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 &amp; Pharmacy Directory on our website at <a href="http://www.villagecaremax.org">www.villagecaremax.org</a>.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered durable medical equipment and supplies.</p> <p>*Prior Authorization is required from VillageCareMAX for certain services/items.</p>

*The plan also covers Medicaid-covered DME and related supplies. See Chapter 13 for more information. .*

Services that are covered for you	What you must pay when you get these services
<p><b>Emergency care</b></p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> <li>• Furnished by a provider qualified to furnish emergency services, and</li> <li>• Needed to evaluate or stabilize an emergency medical condition.</li> </ul> <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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p><b>Additional benefits covered by VillageCareMAX:</b></p> <p>We cover 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>There is no coinsurance, copayment, or deductible for emergency care.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered <i>OR</i> 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>You pay nothing for covered Worldwide Emergency Care.</p>

Services that are covered for you	What you must pay when you get these services
<p> <b>Health and wellness education programs</b></p> <p>You are covered for:</p> <ul style="list-style-type: none"> <li>• Fitness membership through the Silver&amp;Fit Healthy Aging and Exercise program: <ul style="list-style-type: none"> <li>○ Access to fitness centers within the network</li> <li>○ Home fitness kits if you prefer to work out at home</li> <li>○ Coaching via telephone</li> </ul> </li> <li>• 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.</li> </ul>	<p>There is no coinsurance, copayment, or deductible for:</p> <ul style="list-style-type: none"> <li>• Fitness membership</li> <li>• Health and wellness education programs</li> </ul>
<p><b>Hearing services*</b></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><i><b>The plan also covers Medicaid-covered Hearing services. See Chapter 13 for more information.</b></i></p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered exam to diagnose and treat hearing and balance issues.</p> <p>*Prior Authorization required from VillageCareMAX for hearing aids.</p>
<p> <b>HIV screening</b></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"> <li>• One screening exam every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Up to three screening exams during a pregnancy</li> </ul>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>


Services that are covered for you	What you must pay when you get these services
<p><b>Home health agency care*</b></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"> <li>• 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)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered home health services.</p> <p>*Prior Authorization from VillageCareMAX for home health services.</p>
<p><b>Home infusion therapy*</b></p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of 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"> <li>• Professional services, including nursing services, furnished in accordance with the plan of care</li> <li>• Patient training and education not otherwise covered under the durable medical equipment benefit</li> <li>• Remote monitoring</li> <li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier</li> </ul>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered home infusion therapy service.</p> <p>*Prior Authorization required from VillageCareMAX for home infusion therapy services.</p>



**Chapter 4 Medical Benefits Chart (what is covered)**

Services that are covered for you	What you must pay when you get these services
<p><b>Hospice care</b></p> <p>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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <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 your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p>	<p>There is no coinsurance, copayment, or deductible for hospice care.</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 VillageCareMAX Medicare Total Advantage.</p>

Services that are covered for you	What you must pay when you get these services
<b>Hospice care (continued)</b>	
<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 and follow plan rules (such as if there is a requirement to obtain prior authorization).	
<ul style="list-style-type: none"><li>• If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services</li><li>• If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)</li></ul>	
<u>For services that are covered by VillageCareMAX Medicare Total Advantage but are not covered by Medicare Part A or B:</u> VillageCareMAX Medicare Total Advantage 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.	
<u>For drugs that may be covered by the plan's Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 ( <i>What if you're in Medicare-certified hospice</i> ).	
<b>Note:</b> If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	



Services that are covered for you	What you must pay when you get these services
<p> <b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• COVID-19 vaccine</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p>
<p><b>Inpatient hospital care*</b></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"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units (such as intensive care or coronary care units)</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Necessary surgical and medical supplies</li> <li>• Use of appliances, such as wheelchairs</li> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered inpatient hospital care.</p>


Services that are covered for you	What you must pay when you get these services
<p><b>Inpatient hospital care (continued)*</b></p> <ul style="list-style-type: none"> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are 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.</li> <li>• 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.</li> <li>• Physician services</li> </ul>	<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><b>Note:</b> 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 <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> 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>	<p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital.</p> <p>*Prior Authorization required from VillageCareMAX for inpatient hospital care</p>

**Chapter 4 Medical Benefits Chart (what is covered)**

Services that are covered for you	What you must pay when you get these services
<p><b>Inpatient services in a psychiatric hospital*</b></p> <p>Covered services include mental health care services that require a hospital stay</p> <ul style="list-style-type: none"> <li>○ You are covered for up to 190 days for inpatient services in a free-standing psychiatric hospital.</li> <li>○ The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</li> </ul> <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>There is no coinsurance, copayment, or deductible for covered inpatient mental health care.</p> <p>*Prior Authorization from VillageCareMAX for inpatient psychiatric care.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*</b></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"> <li>• Physician services</li> <li>• Diagnostic tests (like lab tests)</li> <li>• X-ray, radium, and isotope therapy including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• 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</li> <li>• 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</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul>	<p>There is no coinsurance, copayment, or deductible for covered inpatient mental health care.</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
<p> <b>Medical nutrition therapy</b></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 physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> <b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p><b>Medicare Part B prescription drugs*</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare Part B prescription drugs</p> <p>*Prior authorization required from VillageCareMAX for certain injectable drugs</p>

Services that are covered for you	What you must pay when you get these services
<b>Medicare Part B prescription drugs (continued)*</b>	
<ul style="list-style-type: none"><li>• Clotting factors you give yourself by injection if you have hemophilia</li><li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li><li>• 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</li><li>• Antigens</li><li>• Certain oral anti-cancer drugs and anti-nausea drugs</li><li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen<sup>®</sup>, Procrit<sup>®</sup>, Epoetin Alfa, Aranesp<sup>®</sup>, or Darbepoetin Alfa)</li><li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li></ul>	
<p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</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> <b>Obesity screening and therapy to promote sustained weight loss</b></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>



Services that are covered for you	What you must pay when you get these services
<p><b>Opioid treatment program services*</b></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"> <li>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.</li> <li>• Dispensing and administration of MAT medications (if applicable)</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Toxicology testing</li> <li>• Intake activities</li> <li>• Periodic assessments</li> </ul>	<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>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies*</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Laboratory tests</li> <li>• 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.</li> <li>• Other outpatient diagnostic tests</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Diagnostic and therapeutic radiological services</li> <li>• Laboratory tests</li> <li>• Medical and surgical supplies</li> </ul> <p>*Prior authorization is required from VillageCareMAX for certain services.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Outpatient hospital observation</b></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><b>Note:</b> 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 Medicare – Ask!” This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> 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>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered outpatient hospital observation.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Outpatient hospital services*</b></p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</li> <li>• Laboratory and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain drugs and biologicals that you can't give yourself</li> </ul> <p><b>Note:</b> 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 Medicare – Ask!" This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> 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>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered outpatient hospital services.</p> <p>*Prior authorization required from VillageCareMAX for certain services.</p>
<p><b>Outpatient mental health care</b></p> <p>Covered services include:</p> <p>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>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered individual or group therapy session.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Outpatient rehabilitation services*</b></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered:</p> <ul style="list-style-type: none"> <li>• Physical Therapy visits</li> <li>• Occupational Therapy visits</li> <li>• Speech Language Therapy visits</li> </ul> <p>*Prior authorization is required from VillageCareMAX.</p>
<p><b>Outpatient substance abuse services*</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Individual and group sessions for counseling or therapy</li> <li>• Treatment of inappropriate alcohol and drug use</li> <li>• Family counseling as needed to help with treatment</li> </ul> <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>

Services that are covered for you	What you must pay when you get these services
<p><b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</b></p> <p><b>Note:</b> 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"> <li>• Ambulatory Surgical Center visit</li> <li>• Outpatient Hospital services</li> </ul> <p>*Prior Authorization is required from VillageCareMAX for certain services.</p>
<p><b>Over-the-Counter (OTC) Health Items</b></p> <p>As a member of VillageCareMAX, you receive an Over-the-Counter (OTC) card with a monthly amount for plan-approved items.</p> <ul style="list-style-type: none"> <li>• <b>You are covered for up to \$2,700 per year (\$225 per month) on your OTC card to buy approved non-prescription drugs and health-related items at participating locations or online for home delivery.</b></li> <li>• Any unused balance will expire at the end of each month and will not carry over to the next month or year.</li> <li>• 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.</li> <li>• The OTC card is not a debit or credit and cannot be converted to cash</li> <li>• Some items are labeled “Dual Purpose” and can only be purchased if recommended by your doctor</li> <li>• Some OTC items may be available to you through Medicaid when you use your Medicaid ID card</li> </ul>	<p>There is no coinsurance, copayment, or deductible for OTC products.</p> <p>Eligible members can also use their monthly benefit amount to get Food &amp; Produce (grocery items). See “Special Supplemental Benefits for the Chronically Ill (SSBCI) – Food &amp; Produce” in this chart for more information.</p>
<p>You can visit our website at <a href="http://www.villagecaremax.org">www.villagecaremax.org</a> or contact Member Services for a comprehensive listing of approved items and more details about how to activate and use your OTC card</p>	


Services that are covered for you	What you must pay when you get these services
<p><b>Partial hospitalization services*</b></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 is required from VillageCareMAX for partial hospitalization services.</p>


Services that are covered for you	What you must pay when you get these services
<p><b>Physician/Practitioner services, including doctor’s office visits*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>• Consultation, diagnosis, and treatment by a specialist</li> <li>• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment</li> <li>• Certain telehealth services, including: 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, and Individual and Group Sessions for Outpatient Substance Abuse. <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ There are different electronic ways to get telehealth services such as through live video and remote patient monitoring. Your provider will tell you how to get access to telehealth services.</li> </ul> </li> <li>• 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</li> </ul>	<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>



**Physician/Practitioner services, including doctor's office visits (continued)\***

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




Services that are covered for you	What you must pay when you get these services
<p><b>Podiatry services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs</li> </ul>	<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>
<p> <b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>
<p><b>Prosthetic devices and related supplies*</b></p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered:</p> <ul style="list-style-type: none"> <li>• Prosthetic devices</li> <li>• Medical supplies</li> </ul> <p>*Prior authorization is required from VillageCareMAX for certain prosthetic devices and medical supplies.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Pulmonary rehabilitation services*</b></p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered pulmonary rehabilitation services.</p> <p>*Prior authorization is required from VillageCareMAX for pulmonary rehabilitation services.</p>
<p> <b>Screening and counseling to reduce alcohol misuse</b></p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <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>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>

Services that are covered for you	What you must pay when you get these services
<p> <b>Screening for lung cancer with low dose computed tomography (LDCT)</b></p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p><b>Eligible members are:</b> 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 coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p>
<p> <b>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</b></p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</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>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

Services that are covered for you	What you must pay when you get these services
<p data-bbox="203 367 630 399"><b>Services to treat kidney disease</b></p> <p data-bbox="203 415 537 447">Covered services include:</p> <ul data-bbox="253 464 1023 1167" style="list-style-type: none"><li data-bbox="253 464 1023 674">• 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 of kidney disease education services per lifetime.</li><li data-bbox="253 684 1023 827">• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)</li><li data-bbox="253 837 1023 905">• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li><li data-bbox="253 915 1023 982">• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li><li data-bbox="253 993 797 1024">• Home dialysis equipment and supplies</li><li data-bbox="253 1035 1023 1167">• 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)</li></ul> <p data-bbox="203 1182 1023 1323">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 data-bbox="1049 375 1414 554">There is no coinsurance or copayment for Medicare-covered services for dialysis and to treat kidney disease and conditions.</p> <p data-bbox="1049 625 1360 766">Notification to VillageCareMAX about dialysis services is preferred.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Skilled nursing facility (SNF) care*</b></p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this document. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>You are covered for up to 100 days each benefit period. There is no prior hospital stay required.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Skilled nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• 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.)</li> <li>• 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.</li> <li>• Medical and surgical supplies ordinarily provided by SNFs</li> <li>• Laboratory tests ordinarily provided by SNFs</li> <li>• X-rays and other radiology services ordinarily provided by SNFs</li> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>• Physician/Practitioner services</li> </ul>	<p>There is no coinsurance, copayment, or deductible for covered skilled nursing facility 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>*Prior Authorization is required from VillageCareMAX for skilled nursing facility services</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Skilled nursing facility (SNF) care (continued)</b></p> <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"> <li>• 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)</li> <li>• A SNF where your spouse is living at the time you leave the hospital</li> </ul>	
<p> <b>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</b></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 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>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>

### **Special Supplemental Benefits for the Chronically Ill – Food & Produce (Grocery Items)**

Members with chronic conditions who meet certain criteria are eligible for Food & Produce (Grocery Items). Eligible members can use their OTC card to get grocery items (in addition to health-related items):

- **Covered for up to \$2,700 per year (\$225 per month) on your OTC card to buy approved grocery items, non-prescription drugs and health-related items at participating locations or online for home delivery.**
- 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

Food & Produce (grocery items) are a part of Special Supplemental Benefits for the Chronically Ill (SSBCI) and not all members may qualify. The criteria include:

- You must have one or more chronic conditions, require intense care coordination, and at a high risk for hospitalization or other adverse health outcomes. In addition, you must get care management services. Upon enrollment,
- The list of chronic conditions are Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke, Osteoporosis; Inflammatory disorders; Eye disorders; Gastrointestinal disorders

Generally, members enrolled in *VillageCareMAX Medicare Total Advantage* meet the criteria and will qualify for SSBCI. Upon enrollment, VillageCareMAX will help determine if you meet the criteria and eligible to receive the benefit.

There is no coinsurance, copayment, or deductible for OTC products and grocery items.


You can visit our website at [www.villagecaremax.org](http://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.


Services that are covered for you	What you must pay when you get these services
<p><b>Special Supplemental Benefits for the Chronically Ill – Transportation for Non-Medical Needs</b></p> <p>Members with chronic conditions who meet certain criteria are eligible for Non-Medical Transportation:</p> <ul style="list-style-type: none"> <li>• <b>Covered for 12 one- way trips (6 round trips) per year for non-medical appointments to plan approved locations via taxi, van, and rideshare services</b></li> </ul> <p>Transportation for Non-Medical Needs are a part of Special Supplemental Benefits for the Chronically Ill (SSBCI) and not all members may qualify. The criteria include:</p> <ul style="list-style-type: none"> <li>• You must have one or more chronic conditions, require intense care coordination, and at a high risk for hospitalization or other adverse health outcomes. In addition, you must get care management services. Upon enrollment,</li> <li>• The list of chronic conditions are Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke, Osteoporosis; Inflammatory disorders; Eye disorders; Gastrointestinal disorders</li> </ul> <p>Generally, members enrolled in <i>VillageCareMAX Medicare Total Advantage</i> meet the criteria and will qualify for SSBCI. Upon enrollment, VillageCareMAX will help determine if you meet the criteria and eligible to receive the benefit.</p>	<p>There is no coinsurance, copayment, or deductible for Non-Medical Transportation.</p> <p>Prior authorization is required from VillageCareMAX for Non-Medical Transportation</p>



Services that are covered for you	What you must pay when you get these services
<p><b>Supervised Exercise Therapy (SET)*</b></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"> <li>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication</li> <li>• Be conducted in a hospital outpatient setting or a physician's office</li> <li>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD</li> <li>• 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</li> </ul> <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 Supervised Exercise Therapy (SET).</p>
<p><b>Transportation services (non-emergency)*</b></p> <p><i>Plan covers Medicaid-covered unlimited transportation trips for medical needs. See Chapter 13 for more information.</i></p> <p><b>Additional benefits covered by VillageCareMAX*:</b></p> <ul style="list-style-type: none"> <li>• Eligible members are covered for Non-Medical Transportation. See “Special Supplemental Benefits for the Chronically Ill – Transportation for Non-Medical Needs” in this chart for more information.</li> </ul>	<p>There is no coinsurance, copayment, or deductible for transportation trips.</p> <p>* Prior authorization is required from VillageCareMAX</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Urgently needed services</b></p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network.</p> <p><b>Additional benefits covered by VillageCareMAX:</b></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>

Services that are covered for you	What you must pay when you get these services
<p data-bbox="203 363 409 415"> <b>Vision care</b></p> <p data-bbox="203 426 537 457">Covered services include:</p> <ul data-bbox="256 478 1019 1140" style="list-style-type: none"><li data-bbox="256 478 1019 657">• 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</li><li data-bbox="256 667 1019 877">• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older</li><li data-bbox="256 888 911 951">• For people with diabetes, screening for diabetic retinopathy is covered once per year</li><li data-bbox="256 961 1019 1140">• 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.)</li></ul> <p data-bbox="203 1182 894 1213"><b>Additional benefits covered by VillageCareMAX*:</b></p> <ul data-bbox="203 1255 948 1360" style="list-style-type: none"><li data-bbox="203 1255 724 1287">• One (1) routine eye exam every year</li><li data-bbox="203 1297 948 1360">• Up to \$350 every year for contact lenses or eyeglasses (lenses and frames)</li></ul> <p data-bbox="203 1402 979 1465"><i>The plan also covers Medicaid-covered vision services. See Chapter 13 for more information.</i></p>	<p data-bbox="1049 373 1409 562">There is no coinsurance, copayment, or deductible for the additional vision benefits covered by VillageCareMAX plan</p> <p data-bbox="1049 625 1409 688">*Prior authorization may be required.</p>

Services that are covered for you	What you must pay when you get these services
<p> <b>“Welcome to Medicare” preventive visit</b></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><b>Important:</b> 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><b>Worldwide Emergency/Urgent Coverage</b></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>The following information is required for all requests to pay for worldwide coverage:</p> <ul style="list-style-type: none"> <li>• Itemized bills (should include date of service, services received, and cost of each item)</li> <li>• Medical records (copies of original medical reports, admission notes, emergency room records, and/or consultation reports)</li> <li>• Proof of payment (receipts or bank or credit card statements)</li> <li>• Proof of travel (copy of itinerary and/or airline tickets)</li> </ul> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for Worldwide Emergency/Urgent Coverage and Emergency Transportation.</p>

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

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

- Medicaid-covered Prescription Drugs
- Office for People with Developmental Disabilities (OPWDD) services
- Out-of-Network Family Planning Services

See Chapter 13 for more information on Medicaid-covered services.

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## **SECTION 4      What services are not covered by the plan?**




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<b>Section 4.1      Services <i>not</i> covered by the plan</b>
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This section tells you what services are “excluded” by Medicare.

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		 <ul style="list-style-type: none"> <li>• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</li> <li>• Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</li> </ul>
<p>Custodial care. (Care that helps with activities of daily living that does not require professional skills or training, e.g. bathing and dressing.)</p> <p>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.</p>		 <p>The plan covers Medicaid-covered custodial care when medically necessary.</p> <p>(See Chapter 13 for more information).</p>
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>		 <p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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>
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>
Home-delivered meals		<p>✓</p> <p>You are covered for 2 meals per day for up to 4 weeks immediately following surgery or inpatient hospitalization</p>
Homemaker services including basic household assistance, such as 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>
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		<p>✓</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		✓ Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.		✓ The plan covers Medicaid-covered dental care services when medically necessary.  (See Chapter 13 for more information).
Radial keratotomy, LASIK surgery, and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).



Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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>
Services considered not reasonable and necessary, according to Original Medicare standards	✓	

# CHAPTER 5:

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



### **How can you get information about your drug costs?**

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs 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 document.)

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## **SECTION 1      Introduction**

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

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage.

<b>Section 1.1      Basic rules for the plan's Part D drug coverage</b>
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare’s Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan’s mail-order service.*)
- Your drug must be on the plan’s *List of Covered Drugs (Formulary)* (we call it the “Drug List” for short). (See Section 3, *Your drugs need to be on the plan’s “Drug List.”*)
- Your drug must be used for a medically accepted indication. 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.)

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

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<b>Section 2.1      Network pharmacies</b>
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### **How do you find a network pharmacy in your area?**

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

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Services or use the *Pharmacy Directory*. You can also find information on our website at [www.villagecaremax.org](http://www.villagecaremax.org).

### **What if you need a specialized pharmacy?**

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact 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 *Pharmacy Directory* or call Member Services.

<b>Section 2.2      Using the plan's mail-order service</b>
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For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or

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

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long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked with an asterisk in our Drug List.

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

To get order forms and information about filling your prescriptions by mail, please review the mail order forms included in your Welcome Packet or contact Postal Prescription Services (PPS) at 1-800-552-6694 or MedImpact Direct Mail® at 1-855-873-8739.

Usually a mail-order pharmacy order will be delivered 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 receive a retail 30-day supply of your prescription 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. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

**Refills on mail-order prescriptions.** For refills, please contact your pharmacy *14* days before your current prescription will run out to make sure your next order is shipped to you in time.

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

<b>Section 2.3</b>	<b>How can you get a long-term supply of drugs?</b>
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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.)

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.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

<b>Section 2.4</b>	<b>When can you use a pharmacy that is not in the plan's network?</b>
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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. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

- You 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 rather than your normal cost share at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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<b>Section 3.1      The "Drug List" tells which Part D drugs are covered</b>
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The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

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

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage.

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

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

The Drug List includes brand name drugs and generic drugs

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, generics work 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 Part D prescription drugs**

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

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

<b>Section 3.3</b>	<b>How can you find out if a specific drug is on the Drug List?</b>
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You have 3 ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website ([www.villagecaremax.org](http://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.)

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<b>SECTION 4</b>	<b>There are restrictions on coverage for some drugs</b>
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<b>Section 4.1</b>	<b>Why do some drugs have restrictions?</b>
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

<b>Section 4.2</b>	<b>What kinds of restrictions?</b>
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The sections below tell you more about the types of restrictions we use for certain drugs.



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**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** Contact 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.)

**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 instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

**Getting plan approval in advance**

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

**Trying a different drug first**

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

**Quantity limits**

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

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**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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<b>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</b>
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There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

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

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- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

<b>Section 5.2</b>	<b>What can you do if your drug is not on the Drug List or if the drug is restricted in some way?</b>
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If your drug is not on the Drug List or is restricted, here are options:

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

**You may be able to get a temporary supply**

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

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

- **If you are a new member**, we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of **30-day supply**. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 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 facility and need a supply right away:**

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

- **For 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

For questions about a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

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

**1) You can change to another drug**

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call 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 are printed on the back cover of this booklet).

**2) You can ask for an exception**

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

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

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

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

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<b>Section 6.1      The Drug List can change during the year</b>
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

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

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

<b>Section 6.2      What happens if coverage changes for a drug you are taking?</b>
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### **Information on changes to drug coverage**

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

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

- **A new generic drug replaces a brand name drug on the Drug List (or we change the 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. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

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

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- 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.

**Other changes to drugs on the Drug List**

- We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30 day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

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

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

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

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

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

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

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

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

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

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

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

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

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## **SECTION 8      Filling a prescription**

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<b>Section 8.1      Provide your membership information</b>
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To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for our share of the costs of your drug. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

<b>Section 8.2      What if you don't have your membership information with you?</b>
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If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

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

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## **SECTION 9      Part D drug coverage in special situations**

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<b>Section 9.1      What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?</b>
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

<b>Section 9.2      What if you're a resident in a long-term care (LTC) facility?</b>
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Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

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

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

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

<b>Section 9.3</b>	<b>What if you're also getting drug coverage from an employer or retiree group plan?</b>
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If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group 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 have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

**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."

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

<b>Section 9.4</b>	<b>What if you're in Medicare-certified hospice?</b>
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Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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



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## **SECTION 10      Programs on drug safety and managing medications**

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<b>Section 10.1      Programs to help members use drugs safely</b>
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

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

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

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you.

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

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

<b>Section 10.3</b>	<b>Medication Therapy Management (MTM) program to help members manage their medications</b>
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We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services).

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## **SECTION 3      We send you reports that explain payments for your drugs and which payment stage you are in**

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<b>Section 3.1</b>	<b>We send you a monthly summary called the <i>Part D Explanation of Benefits</i> (the “Part D EOB”)</b>
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Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

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

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *Part D Explanation of Benefits* (“Part D EOB”). 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 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 information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

<b>Section 3.2</b>	<b>Help us keep our information about your drug payments up to date</b>
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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 every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of

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your out-of-pocket costs, give us copies of these receipts. Here are examples of when you should give us copies of your drug receipts:

- When you purchase a covered drug at a network pharmacy at a special price or 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

If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Be sure to keep these reports.

# 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 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.”

**Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call your Member Services for more information.

**Important Message About What You Pay for Insulin** – You won’t pay more than \$0 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on.

## CHAPTER 7:

*Asking us to pay our share of 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**

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Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of 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 more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

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

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

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

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

### **3. If you are retroactively enrolled in our plan**

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

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

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

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

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

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

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

### **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. Contact the plan for more information.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

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<b>Section 2.1      How and where to send us your request for payment</b>
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You may request us to pay you back by sending a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It’s a good idea to keep a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you received the service, item, or drug.

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

- You don’t have to use the form, but it will help us process the information faster. The information we need to make a decision include:
  - **Member Information** – Name, Member ID, Address, Telephone
  - **Service Information** – Type of Service, Date of Service, Provider’s Name/Contact Information, Total Paid

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

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- **Supporting Documentation** – Receipt (proof of payment), Bill or Provider claim form listing diagnosis & procedures
- Either download a copy of the form from our website ([www.villagecaremax.org](http://www.villagecaremax.org)) or call Member Services and ask for the form.

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

VillageCareMAX  
112 Charles Street  
New York NY 10014

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 our share of the cost 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 don’t know what you should have paid, or 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.

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

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<b>Section 3.1      We check to see whether we should cover the service or drug</b>
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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, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement: of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. We will send you a

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

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letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

<b>Section 3.2</b>	<b>If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal</b>
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If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

# CHAPTER 8:

## *Your rights and responsibilities*

**Chapter 8 Your rights and responsibilities**

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**SECTION 1      Our plan must honor your rights and cultural sensitivities as a member of the plan**

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<b>Section 1.1</b>	<b>We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)</b>
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Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can 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.

Our plan is required give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with 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 1-800-368-1019 or TTY 1-800-537-7697.

Su plan está obligado a asegurar que todos los servicios, tanto los clínicos como los no clínicos, sean brindados de un modo culturalmente competente y sean accesibles a todas las personas inscritas que incluyen a aquellas con dominio limitado del inglés, aptitudes limitadas de lectura, incapacidad auditiva o aquellas con diversos orígenes culturales y étnicos. Ejemplos de cómo un plan podría cumplir con todos estos requisitos de accesibilidad son, entre otros, la prestación de servicios de traducción e interpretación, teletipos o conexión de TTY (teléfono de texto o de teletipo).

**Chapter 8 Your rights and responsibilities**

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Nuestro plan tiene servicios gratuitos de intérprete que responde a las preguntas hechas por los miembros que no hablan inglés. Podemos proporcionar materiales escritos en español y chino. También podemos darle información sin costo en braille, letras grandes o en otros formatos alternativos si los necesita. Estamos obligados a informarle sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para recibir información de nosotros de una manera que funcione para usted, llame por favor a Servicios a Miembros.

Nuestro plan está obligado a darles a las mujeres inscritas la opción de tener acceso directo a un especialista en salud femenina que está dentro de la red para los servicios habituales y preventivos de la salud de la mujer.

Si los proveedores que están en la red del plan para una especialidad no están disponibles, es la responsabilidad del plan encontrar a proveedores especialistas que están fuera del plan que le proporcionarán los cuidados necesarios. En este caso, usted solo pagará el costo compartido dentro de la red. Si usted se encuentra en una situación en la cual no hay especialistas pertenecientes a la red del plan que le presten un servicio que necesita, llame al plan para pedir información sobre adónde acudir para obtener este servicio compartiendo el costo dentro de la red.

Si tiene cualquier problema para recibir información de nuestro plan en un formato accesible y adecuado para usted, le pedimos que le presente una queja al Departamento de Quejas de VillageCareMAX llamando al 1-800-469-6292 (TTY: 711). También puede presentarle una queja a Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina para los Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

您的計劃必須確保以符合文化能力的方式提供所有的服務，包含臨床及非臨床兩類，並讓所有投保者皆能使用，包含擁有有限英語能力、閱讀障礙、聽力障礙或多元文化及種族背景的投保者。以下為計劃如何符合無障礙需求的範例，包含但不設限於提供文字翻譯員服務、口譯員服務、電傳打字機或 TTY 連線（文字電話或是電傳打字機電話）。

我們的計劃提供免費的口譯員服務，可以回答母語非英語會員的問題。我們能提供西班牙文及中文的書面資料。如果有需要，我們也能免費以盲文版、大字版或其他替代格式提供您資訊。我們必須以合適及適當的格式提供您關於此計劃福利的資訊。如果您需要以適合您的方式向我們索取資料，請致電會員服務部。

我們的計劃必須為女性投保者提供直接向網絡內的女性健康專科醫生尋求女性常規及預防健康照護服務的選項。

如果計劃的網絡中沒有某項專科的醫療服務提供者，在網絡外找出能提供您所需照護的專科醫療服務提供者則是該計劃的責任。在此情況下，您只需要支付網絡內的成本負擔。如

**Chapter 8 Your rights and responsibilities**

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果您發現計劃的網絡中沒有負責提供您所需服務的專科醫生，請致電詢問該計劃以瞭解關於如何用網絡內的成本負擔取得所需服務的資訊。

如果我們的計劃無法提供您以合適及適當的方式取得資訊，您可以致電 VillageCareMAX 的申訴部門提出投訴，請撥打 1-800-469-6292 (TTY : 711)。您也可以透過致電 1-800-MEDICARE (1-800-633-4227) 向 Medicare 提出申訴亦是直接撥打 1-800-368-1019 或 TTY 1-800-537-7697 與民權辦公室聯絡。

<b>Section 1.2</b>	<b>We must ensure that you get timely access to your covered services and drugs</b>
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You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals: to go to network providers.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

<b>Section 1.3</b>	<b>We must protect the privacy of your personal health information</b>
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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.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

**How do we protect the privacy of your health information?**

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get*



**Chapter 8 Your rights and responsibilities**

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*written permission from you or someone you have given legal power to make decisions for you first.*

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

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

As a member of VillageCareMAX Medicare Total Advantage, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.

**Chapter 8 Your rights and responsibilities**

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- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

<b>Section 1.5</b>	<b>We must support your right to make decisions about your care</b>
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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. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

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

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

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

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

**Chapter 8 Your rights and responsibilities**

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. 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 who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

**What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the 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

<b>Section 1.6</b>	<b>You have the right to make complaints and to ask us to reconsider decisions we have made</b>
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

<b>Section 1.7</b>	<b>What can you do if you believe you are being treated unfairly or your rights are not being respected?</b>
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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, sexual orientation, 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.**
- You can **call the State Health Insurance Program (SHIP).** For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

- You can **call Member Services.**
- You can **call the State Health Insurance Program (SHIP).** For details, go to Chapter 2, Section 3.
- You can contact **Medicare.**

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- 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](http://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 1-877-486-2048).

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**SECTION 2      You have some responsibilities as a member of the plan**

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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.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.

**Chapter 8 Your rights and responsibilities**

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- If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

# CHAPTER 9

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

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## **SECTION 1 Introduction**

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<b>Section 1.1 What to do if you have a problem or concern</b>
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This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

**Section 3** will help you identify the right process to use and what you should do.

<b>Section 1.2 What about the legal terms?</b>
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There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” and “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. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

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## **SECTION 2 Where to get more information and personalized assistance**

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We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.



## **State Health Insurance Assistance Program (SHIP)**

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

## **Medicare**

You can also contact Medicare to get help. To contact Medicare:

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

## **You can get help and information from Medicaid**

If you have questions about the assistance you get from Medicaid, contact the managed care enrollment program of New York State Department of Health:

<b>Method</b>	<b>New York Medicaid Choice – Contact Information</b>
<b>CALL</b>	1-800-401-6582 Calls to this number are free. Available Monday through Friday, 8:30 am to 8:00 pm, and Saturday from 10:00 am to 6:00 pm.
<b>TTY</b>	1-888-329-1541 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available Monday through Friday, 8:30 am to 8:00 pm, and Saturday from 10:00 am to 6:00 pm.
<b>WEBSITE</b>	<a href="http://www.nymedicaidchoice.com">www.nymedicaidchoice.com</a>

The Independent Consumer Advocacy Network (ICAN) helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	Independent Consumer Advocacy Network (ICAN) – Contact Information
<b>CALL</b>	1-844-614-8800 Calls to this number are free Available Monday through Friday from 9:00 am to 5:00 pm
<b>TTY</b>	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 Available Monday through Friday from 9:00 am to 5:00 pm
<b>WRITE</b>	Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 633 Third Ave, 10 <sup>th</sup> Floor New York NY 10017
<b>WEBSITE</b>	<a href="http://www.icannys.org">www.icannys.org</a>

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

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You have Medicare and get assistance from Medicaid. Information in this chapter applies to **all** of your Medicare and **most** of your 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 combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4** of this chapter, “Step-by-step: How a Level 2 appeal is done.”

## **PROBLEMS ABOUT YOUR BENEFITS**

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### **SECTION 4 Coverage decisions and appeals**

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

#### **Is your problem or concern about your benefits or coverage?**

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

**Yes.**

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

**No.**

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.”**

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

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

#### **Asking for coverage decisions prior to receiving services**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, if your plan network doctor refers you to a medical specialist, this is a (favorable) coverage decision.

If your doctor, whether the doctor is in our network or outside it, is unsure whether we will cover a medical service, you or your doctor can contact us and ask for a coverage decision prior to receiving the service. This is called an “advanced determination,” or prior authorization. You or your doctor can also request that the response be in writing if you would like a copy of the decision for your records. 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 an initial coverage decision for you. If your plan denies the coverage asked about in the advanced determination, then your plan must issue a standardized denial notice informing you or your doctor of your right to appeal this decision.

If you do not have an advanced determination, authorization for services can also be obtained from a network provider who refers an enrollee to a specialist. This can also be a provider outside of the plan’s network. However, the service cannot be a service that is explicitly excluded from plan coverage (that is, never covered by the plan) as discussed in Chapter 4. If the enrollee receives an authorization from the provider and the service is not an excluded service, the enrollee only has to pay plan-cost sharing. If the plan attempts to charge the enrollee more, the enrollee can formally request a review called an appeal. This is discussed in the next section.

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. This review is a formal process called an appeal. Appeals are discussed in the next section.

## **Making an appeal**

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or “fast appeal” of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won’t review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn’t legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, your appeal will automatically go on to Level 2. The Level 2 appeal is conducted by the Office of Administrative Hearings. They are not connected to us.

- Your case will be automatically sent to the Office of Administrative Hearings for a Level 2 appeal – you do not have to do anything. The Office of Administrative Hearings will mail you a notice to confirm they received your Level 2 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the Level 2 appeal decision, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

<b>Section 5.2</b>	<b>How to get help when you are asking for a coverage decision or making an appeal</b>
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services 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](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [www.villagecaremax.org](http://www.villagecaremax.org).)
  - 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 health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services 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](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [www.villagecaremax.org](http://www.villagecaremax.org).) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Office of Administrative Hearings to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

If you're not sure which section you should be using, call Member Services. You can also get help or information from government organizations such as your SHIP.

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

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<b>Section 6.1</b>	<b>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</b>
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
  2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
  3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
  4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
  5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**
- **Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a Sections 8 and 9 of this chapter. Special rules apply to these types of care.**

<b>Section 6.2</b>	<b>Step-by-step: How to ask for a coverage decision</b>
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<b>Legal Terms</b>
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When a coverage decision involves your medical care, it is called an <b>“integrated organization determination.”</b>
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A “fast coverage decision” is called an <b>“expedited determination.”</b>
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**Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”**

A “standard coverage decision” is usually made within 14 days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

**Step 2: Ask our plan to make a coverage decision or fast coverage decision.**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.



**Step 3: We consider your request for medical care coverage and give you our answer.**

*For standard coverage decisions we use the standard deadlines.*

**This means we will give you an answer within 14 calendar days** after we receive your request for a medical item or service. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. If the extra days are because we need more information, we will tell you what information we need 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

*For Fast Coverage decisions we use an expedited timeframe*

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

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

**Step 4: If we say no to your request for coverage for medical care, you can appeal.**

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

<b>Section 6.3</b>	<b>Step-by-step: How to make a Level 1 appeal</b>
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<b>Legal Terms</b>
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An appeal to the plan about a medical care coverage decision is called a plan **“integrated reconsideration.”**

A “fast appeal” is also called an **“expedited reconsideration.”**

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

A “standard appeal” is usually made within 30 days. A “fast appeal” is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.2 of this chapter.

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 15 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

### **Step 3: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

#### ***Deadlines for a “fast appeal”***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the Office of Administrative Hearings for a Level 2 appeal. The Office of Administrative Hearings

will schedule a hearing on your case, and let you know the date and time of the hearing in writing.

### ***Deadlines for a “standard” appeal***

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should **not** take extra days, you can file a “fast complaint.” When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where Office of Administrative Hearings will have a hearing on your case. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage 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 plan says no to part or all of your appeal, you have additional appeal rights. We will automatically send your request to a Level 2 appeal where the Office of Administrative Hearings will have a hearing on your case to see if they agree with our decision.**
- If we say no to part or all of what you asked for, we will send you a letter.

<b>Section 6.4</b>	<b>Step-by-step: How a Level 2 appeal is done</b>
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The Office of Administrative Hearings **is an independent organization hired by Medicare and Medicaid**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare and Medicaid oversees its work.

We will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete. The Office of Administrative Hearings will schedule a hearing in your case and let you know of the date and time. You can ask to reschedule for a different day or time if needed.

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 146 for information about continuing your benefits during Level 1 appeals.

### **Level 2 Appeals Process:**

#### **Step 1: We will send your case to the Office of Administrative Hearings. The Office of Administrative Hearings will have a hearing on your case.**

- We will send the information about your appeal to this organization. This information is called your “case file” or “Evidence Packet.” **We will send you a free copy of your Evidence Packet.**
- You have a right to give the Office of Administrative Hearings additional information to support your appeal.
- During your hearing, the Hearing Officer at the Office of Administrative Hearings will take a careful look at all of the information related to your appeal, and will hear from you and from staff from your plan about your request.

#### ***If you had a “fast” appeal at Level 1, you MAY also have a “fast” appeal at Level 2***

- For the “fast appeal” the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal. In some cases, even though you had a fast appeal for 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 regain maximum 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***

- For the “standard appeal” if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 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.
- However, 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.

## **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.

- **If the Office of Administrative Hearings says yes to part or all of your request,** we must authorize the medical care coverage **within 1 business day.**
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”) In this case, the Office of Administrative Hearings will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the Office of Administrative Hearings will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
  - The Level 3 appeal is handled by the Medicare Appeals Council. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

## **If the decision is no for all or part of what I asked for, can I make another appeal?**

If the Office of Administrative Hearings decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Office of Administrative Hearings will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

<b>Section 6.5</b>	<b>What if you are asking us to pay you back for a bill you have received for medical care?</b>
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If you have already paid for a Medicaid 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.

**Asking for reimbursement is asking for a coverage decision from us.**

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost within 60 calendar days after we receive your request.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

**To make this appeal, follow the process for appeals that we describe in Section 6.3.** For appeals concerning reimbursement, please note:

- We must give you our answer within 30 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the Office of Administrative Hearings decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the health care provider within 60 calendar days.

<b>Section 6.6</b>	<b>External Appeals for Medicaid Only</b>
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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](http://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.**

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## **SECTION 7      Your Part D prescription drugs: How to ask for a coverage decision or make an appeal**

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<b>Section 7.1</b>	<b>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</b>
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Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6.

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

## Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a <b>“coverage determination.”</b>

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan’s *List of Covered Drugs*. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

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

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

<b>Section 7.2</b>	<b>What is an exception?</b>
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Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a <b>“formulary exception.”</b>
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a <b>“formulary exception.”</b>
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a <b>“tiering exception.”</b>

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

<b>Section 7.3</b>	<b>Important things to know about asking for exceptions</b>
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**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

**We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

<b>Section 7.4</b>	<b>Step-by-step: How to ask for a coverage decision, including an exception</b>
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<b>Legal Term</b>
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A “fast coverage decision” is called an “ <b>expedited coverage determination.</b> ”
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**Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”**

“**Standard coverage decisions**” are made within **72 hours** after we receive your doctor’s statement. “**Fast coverage decisions**” are made within **24 hours** after we receive your doctor’s statement.

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

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

**Step 2: Request a “standard coverage decision” or a “fast coverage decision.”**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan’s form, which are available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the “supporting statement,”** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

**Step 3: We consider your request and give you our answer.**

***Deadlines for a “fast coverage decision”***

- We must generally give you our answer **within 24 hours** after we receive your request.

- For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a "standard" coverage decision about a drug you have not yet received***

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a "standard" coverage decision about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

**Step 4: If we say no to your coverage request, you can make an appeal.**

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

<b>Section 7.5</b>	<b>Step-by-step: How to make a Level 1 appeal</b>
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Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”
A “fast appeal” is also called an “expedited redetermination.”

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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

**Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a “fast appeal.”**

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-888-807-6806 (TTY: 711).** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented

you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

### **Step 3: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

#### ***Deadlines for a “fast appeal”***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

#### ***Deadlines for a “standard” appeal for a drug you have not yet received***

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 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. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

#### ***Deadlines for a “standard appeal” about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

**Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

<b>Section 7.6</b>	<b>Step-by-step: How to make a Level 2 appeal</b>
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<b>Legal Term</b>
The formal name for the “independent review organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”

The **independent review organization** is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

**Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding “at-risk” determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.



## **Step 2: The independent review organization reviews your appeal.**

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

### ***Deadlines for “fast appeal”***

- If your health requires it, ask the independent review organization for a “fast appeal.”
- If the organization agrees to give you a “fast appeal,” the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

### ***Deadlines for “standard appeal”***

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

## **Step 3: The independent review organization gives you their answer.**

- ***For “fast appeals”:***
  - **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.
- ***For “standard appeals”:***
  - **If the independent review organization says yes to part or all of your 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 says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

## **What if the review organization says no to your appeal?**

**If this organization says no to part or all of your appeal,** it means they agree with our decision not to approve your request (or part of your request). (This is called “upholding the decision” or “turning down your appeal.”) In this case, the independent review organization will send you a letter:

- Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

**Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go on to Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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**SECTION 8      How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon**

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.”
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

<p><b>Section 8.1      During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</b></p>
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Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice.

If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

**1. Read this notice carefully and ask questions if you don't understand it.** It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

**2. You will be asked to sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

**3. Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services 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 the notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices](http://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.**

- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

**Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.**

*How can you contact this organization?*

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

*Act quickly:*

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge**.
  - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
  - If you do **not** meet this deadline and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see **Section 8.4** of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 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](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices).

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

- Health professionals at the Quality Improvement Organization ( “the reviewers”) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

*What happens if the answer is yes?*

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

*What happens if the answer is no?*

- If the review organization says no, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has said *no* to your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 8.3</b>	<b>Step-by-step: How to make a Level 2 appeal to change your hospital discharge date</b>
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

**Step 1: Contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.**

***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

***If the review organization says no:***

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 8.4</b>	<b>What if you miss the deadline for making your Level 1 appeal?</b>
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<b>Legal Term</b>
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A “fast review” (or “fast appeal”) is also called an <b>“expedited appeal.”</b>
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### **You can appeal to us instead**

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

### **Step-by-Step: How to make a Level 1 Alternate appeal**

#### **Step 1: Contact us and ask for a “fast review.”**

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

#### **Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

#### **Step 3: We give you our decision within 72 hours after you ask for a “fast review”.**

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)

- **If we say no to your appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

**Step 4: If we say *no* to your appeal, your case will automatically be sent on to the next level of the appeals process.**

### **Step-by-Step: Level 2 *Alternate* appeal Process**

Legal Term
The formal name for the “independent review organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”

**The independent review organization is an independent organization hired by Medicare.** It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

**Step 1: We will automatically forward your case to the independent review organization.**

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. **Section 11** of this chapter tells how to make a complaint.)

**Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.



**Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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**SECTION 9      How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

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<b>Section 9.1</b>	<b>This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</b>
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When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying 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.

<b>Section 9.2</b>	<b>We will tell you in advance when your coverage will be ending</b>
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<b>Legal Term</b>
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<b>“Notice of Medicare Non-Coverage.”</b> It tells you how you can request a <b>“fast-track appeal.”</b> Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.
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1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
  - The date when we will stop covering the care for you.

- How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan’s decision to stop care.

<b>Section 9.3</b>	<b>Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time</b>
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it’s time to stop covering certain kinds of medical care. These experts are not part of our plan.

**Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.**

*How can you contact this organization?*

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.
- ***Act quickly:***
  - You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

*Your deadline for contacting this organization.*

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see **Section 9.5** of this chapter.

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

Legal Term
“ <b>Detailed Explanation of Non-Coverage.</b> ” Notice that provides details on reasons for ending coverage.

*What happens during this review?*

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you, or your representative, why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

**Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**

*What happens if the reviewers say yes?*

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

*What happens if the reviewers say no?*

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

**Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.**

- If reviewers say no to your Level 1 appeal **and** you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

<b>Section 9.4</b>	<b>Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time</b>
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

**Step 1: Contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.**

*What happens if the review organization says yes?*

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

*What happens if the review organization says no?*

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next

level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

<b>Section 9.5</b>	<b>What if you miss the deadline for making your Level 1 appeal?</b>
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**You can appeal to us instead**

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different.**

**Step-by-Step: How to make a Level 1 Alternate appeal**

Legal Term
A “fast review” (or “fast appeal”) is also called an “ <b>expedited appeal.</b> ”

**Step 1: Contact us and ask for a “fast review.”**

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

**Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.**

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review”.**

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share

of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)

- **If we say no to your appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, 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.

**Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.**

Legal Term
The formal name for the “independent review organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”

### **Step-by-Step: Level 2 Alternate appeal Process**

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your “fast appeal.” This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

**Step 1: We automatically forward your case to the independent review organization.**

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. **Section 11** of this chapter tells how to make a complaint.)

**Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are

coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.

- **If this organization says no to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

**Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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## **SECTION 10 Taking your appeal to Level 3 and beyond**

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<b>Section 10.1 Levels of Appeal 3, and 4 for Medical Service Appeals</b>
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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 Integrated Administrative Hearing Office (IAHO) 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.

<b>Level 5 appeal</b> A judge at the <b>Federal District Court</b> will review your appeal.
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- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## **Section 10.2 Additional Medicaid appeals**

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

## **Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests**

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 appeal** An Administrative Law Judge or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal** The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for**



**expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 appeal** A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## **SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns**

### **Section 11.1 What kinds of problems are handled by the complaint process?**

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

<b>Complaint</b>	<b>Example</b>
<b>Quality of your medical care</b>	<ul style="list-style-type: none"><li>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</li></ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"><li>• Did someone not respect your right to privacy or share confidential information?</li></ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"><li>• Has someone been rude or disrespectful to you?</li><li>• Are you unhappy with our Member Services?</li><li>• Do you feel you are being encouraged to leave the plan?</li></ul>

Complaint	Example
<b>Waiting times</b>	<ul style="list-style-type: none"> <li>• Are you having trouble getting an appointment, or waiting too long to get it?</li> <li>• 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"> <li>○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.</li> </ul> </li> </ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?</li> </ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"> <li>• Did we fail to give you a required notice?</li> <li>• Is our written information hard to understand?</li> </ul>
<b>Timeliness</b> (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> <li>• You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint.</li> <li>• You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.</li> <li>• You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint.</li> <li>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.</li> </ul>

<b>Section 11.2</b>	<b>How to make a complaint</b>
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<b>Legal Terms</b>
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- A “Complaint” is also called a “grievance.”
- “Making a complaint” is also called “filing a grievance.”
- “Using the process for complaints” is also called “using the process for filing a grievance.”
- A “fast complaint” is also called an “expedited grievance.”

<b>Section 11.3</b>	<b>Step-by-step: Making a complaint</b>
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**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.
- 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.
- [Insert description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint. Describe expedited grievance time frames for grievances about decisions to not conduct expedited organization/coverage determinations or reconsiderations/redeterminations.]
- **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.

**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint cause we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

<b>Section 11.4</b>	<b>You can also make complaints about quality of care to the Quality Improvement Organization</b>
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When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.
- *Or*
- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

<b>Section 11.5</b>	<b>You can also tell Medicare and Medicaid about your complaint</b>
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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 [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

You can also contact the New York State Department of Health to submit a complaint at 1-866-712-7197 or at the address below:

NYS Department of Health  
Bureau of Managed Long Term Care  
Room 1911 Corning Tower  
Empire State Plaza  
Albany, NY 12237

# CHAPTER 10:

## *Ending your membership in the plan*

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## **SECTION 1      Introduction to 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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## **SECTION 2      When can you end your membership in our plan?**

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<b>Section 2.1      You may be able to end your membership because you have Medicare and Medicaid</b>
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Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- **Choose any of the following types of Medicare plans:**
  - Another Medicare health plan, with or without prescription drug coverage
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare without a separate Medicare prescription drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage 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.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

<b>Section 2.2</b>	<b>You can end your membership during the Annual Enrollment Period</b>
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You can end your membership during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

*OR*

- Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

**If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

<b>Section 2.3</b>	<b>You can end your membership during the Medicare Advantage Open Enrollment Period</b>
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

<b>Section 2.4</b>	<b>In certain situations, you can end your membership during a Special Enrollment Period</b>
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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**.

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)):

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

**Note:** If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

**Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 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. You can choose:
  - Another Medicare health plan with or without prescription drug coverage.



- Original Medicare *with* a separate Medicare prescription drug plan

*OR*

- Original Medicare *without* a separate Medicare prescription drug plan.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

**If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Your membership will usually end** on the first day of the month after your request to change your plan is received.

**Note:** Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

<b>Section 2.5</b>	<b>Where can you get more information about when you can end your membership?</b>
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If you have any questions about ending your membership you can:

- **Call Member Services**
- Find the information in the *Medicare & You 2023* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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## **SECTION 3      How do you end your membership in our plan?**

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The table below explains how you should end your membership in our plan.

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
Another Medicare health plan	<ul style="list-style-type: none"><li>• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month.</li><li>• You will automatically be disenrolled from VillageCareMAX Medicare Total Advantage when your new plan’s coverage begins.</li></ul>

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
Original Medicare <i>with</i> a separate Medicare prescription drug plan	<ul style="list-style-type: none"><li>• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month.</li><li>• You will automatically be disenrolled from VillageCareMAX Medicare Total Advantage when your new plan's coverage begins.</li></ul>
Original Medicare <i>without</i> a separate Medicare prescription drug plan <ul style="list-style-type: none"><li>○ 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.</li><li>○ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.</li></ul>	<ul style="list-style-type: none"><li>• <b>Send us a written request to disenroll</b> Contact Member Services if you need more information on how to do this.</li><li>• You can also contact <b>Medicare</b>, 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.</li><li>• You will be disenrolled from VillageCareMAX Medicare Total Advantage when your coverage in Original Medicare begins.</li></ul>

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Medicaid benefits, contact *New York Medicaid Choice* at 1-800-401-6582 (TTY: 1-888-329-1541). The business hours are Monday through Friday from 8:30 am to 8:00 pm, and Saturday from 10:00 am to 6:00 pm. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

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## **SECTION 4      Until your membership ends, you must keep getting your medical services and drugs through our plan**

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Until your membership VillageCareMAX Medicare Total Advantage ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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## **SECTION 5      VillageCareMAX Medicare Total Advantage must end your membership in the plan in certain situations**

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<b>Section 5.1      When must we end your membership in the plan?</b>
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**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 move out of our service area
- If you are away from our service area for more than six months
  - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan

## **Where can you get more information?**

If you have questions or would like more information on when we can end your membership call Member Services.

<b>Section 5.2</b>	<b>We <u>cannot</u> ask you to leave our plan for any health-related reason</b>
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VillageCareMAX Medicare Total Advantage is not allowed to ask you to leave our plan for any health-related reason.

## **What should you do if this happens?**

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

<b>Section 5.3</b>	<b>You have the right to make a complaint if we end your membership in our plan</b>
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

# CHAPTER 11:

## *Legal notices*

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## **SECTION 1      Notice about governing law**

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The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

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## **SECTION 2      Notice about nondiscrimination**

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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, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index>.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

**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 help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

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- 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, call **VillageCareMAX** at 1-800-469-6292. For TTY/TDD services, call 711.

If you believe that **VillageCareMAX** has not given you 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: 112 Charles Street, New York NY 10014  
Phone: 1-800-469-6292 (TTY: 711)  
Fax: 1-347-226-5180  
In person: 112 Charles Street, New York, NY 10014  
Email: [Complaints@villagecare.org](mailto: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 by:

Web: Office for Civil Rights Complaint Portal at  
<https://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, DC 20201  
Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>  
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

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### **SECTION 3      Notice about Medicare Secondary Payer subrogation rights**

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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.

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## **SECTION 4      Notice of Privacy Practices**

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**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](http://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:

- 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.



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- 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 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

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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 possible treatment alternatives or health-related benefits and services that may be of interest to you.

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**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 212-337-5637.*

**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

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;
- 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;

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- 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.

**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](http://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](http://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](http://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**

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**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

**Benefit Period** – The way that 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 have not 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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$7,400 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare.

**Chronic-Care Special Needs Plan - C-SNPs** are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-A SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

**Coinsurance** – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

**Complaint** — The formal name for “making a complaint” is “filing a grievance.” The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.



**Chapter 12 Definitions of important words**

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**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or “copay”)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this document.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Daily cost-sharing rate** – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day.

**Chapter 12 Definitions of important words**

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**Deductible** – The amount you must pay for health care or prescriptions before our plan pays.

**Disenroll or Disenrollment** – The process of ending your membership in our plan.

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

**Dual Eligible Special Needs Plans (D-SNP)** – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

**Dual Eligible Individual** – A person who qualifies for Medicare and Medicaid coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

**Emergency Care** – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Chapter 12 Definitions of important words**

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**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 person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. 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.

**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 \$4,660 OR out-of-pocket costs reach \$7,400.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Institutional Special Needs Plan (SNP)** – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF); an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

**Chapter 12 Definitions of important words**

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**Institutional Equivalent Special Needs Plan (SNP)** – A 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.

**Integrated Grievance** – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

**Integrated Organization Determination** – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this document.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of prescription drugs covered by the plan.

**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 A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. (**Note:** Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.)

**Medicaid (or Medical Assistance)** – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Open Enrollment Period** – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

**Chapter 12 Definitions of important words**

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**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network Pharmacy** – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Chapter 12 Definitions of important words**

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**Network Provider** – “Provider” is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. “**Network providers**” have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers.”

**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 does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

**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. 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.

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

**Part D Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

**Chapter 12 Definitions of important words**

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**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 Physician OR Provider (PCP)** –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** –Approval in advance to get services or certain drugs Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

**Prosthetics and Orthotics** – Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Chapter 12 Definitions of important words**

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**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** – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.



# CHAPTER 13

## VillageCareMAX Medicaid Advantage Plus (MAP) Member Handbook

**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.

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## **SECTION 1      What Makes VillageCareMAX Special?**

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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).

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## **SECTION 2      Who is Eligible to Join VillageCareMAX?**

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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 these counties in *New York*: Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Nassau, Richmond (Staten Island) and Westchester.
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.

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## **SECTION 3      How do I enroll?**

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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 can call VillageCareMAX at 1-800-469-6292. TTY users should call 711. Our hours are 8:00 am to 8:00 pm, 7 days a week.** We will talk to you about your health needs, benefits, and the enrollment process.

If you are new to Community Based Long Term Care Services, we will put you in touch with the New York Independent Assessor (NYIA). You may also call NYIA at 1-855-222-8350. The hours are Monday through Friday, from 8:30 am to 8:00 pm; and Saturday & Sunday 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) plan, we will put you in touch with the State's enrollment broker (New York Medicaid Choice). You may also call them at **1-888-401-6582. TTY users should call 1-888-329-1541.** The hours are Monday through Friday, from 8:30 am to 8:00 pm; and Saturday from 10:00 am to 6:00 pm.

### **New York Independent Assessor - Initial Assessment Process**

Starting May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) will become the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process, except for expedited initial assessments, which will begin on July 1, 2022. The initial assessment process includes completing the:

- *Community Health Assessment (CHA)*: The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.
- *Clinical appointment and Practitioner Order (PO)*: The PO documents your clinical appointment and indicates that you:
  - have a need for help with daily activities, and
  - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

VillageCareMAX will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to VillageCareMAX about whether the plan of care meets your needs.

### **Enrollment Steps for Medicare**

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 Total 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 20<sup>th</sup> 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.

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## **SECTION 4      Which Providers Can I Use?**

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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](http://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 timeframes:

<b>Service</b>	<b>Standard</b>
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.
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### ***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.

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## **SECTION 5      What Medicaid Services are Covered by VillageCareMAX Medicaid Advantage Plus (MAP) Program?**

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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
<p><b>Adult Day Health Care</b></p> <p>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 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>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 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><b>Audiology/Hearing Aids not covered by Medicare</b></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><b>Care Management by a Registered Nurse or Social Worker</b></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><b>Consumer Directed Personal Assistance</b></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>

Service	Coverage Rules
<p><b>Dental</b></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</p>
<p><b>Durable Medical Equipment (DME) not covered by Medicare</b></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><b>Home-Delivered Meals and/or Meals in a Group Setting</b></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><b>Home Health Care Services Not Covered by Medicare</b></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><b>Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit</b></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>

Service	Coverage Rules
<p><b>Medical Social Services</b></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>
<p><b>Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies</b></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><b>Non-emergency Transportation</b></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><b>Nursing Home Care not covered by Medicare</b></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>

Service	Coverage Rules
<p><b>Nutrition Services/Counseling</b></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><b>Optometry/Eyeglasses</b></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. Prior authorization may be required.</p>
<p><b>Outpatient Mental Health &amp; Substance Abuse</b></p> <p>Services to treat mental health and substance abuse conditions in an outpatient setting.</p> <p><i>See “Behavioral Health (mental health and addiction) services” below for additional services</i></p>	<p>You must get outpatient mental health &amp; 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 required for certain services.</p>
<p><b>Personal Care</b></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, 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>
<p><b>Personal Emergency Response Systems (PERS)</b></p> <p>PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or</p>	<p>You must get PERS from the VillageCareMAX Provider Network, and you must get authorization from the Plan.</p>

Service	Coverage Rules
environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	
<p><b>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home</b></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>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 and get authorization from the Plan.</p>
<p><b>Podiatry services not covered by Medicare</b></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><b>Private Duty Nursing</b></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>

Service	Coverage Rules
<p><b>Prosthetics, Orthotics and Orthopedic Footwear</b></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, 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 obtaining doctor's orders if needed.</p>
<p><b>Respiratory Therapy</b></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><b>Social and Environmental Supports</b></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><b>Social Day Care</b></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>



Service	Coverage Rules
<p><b>Telehealth</b></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>
<p><b>Veteran's Home Services</b></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

## **Behavioral Health (mental health and addiction) Services**

Starting January 1, 2023, VillageCareMAX Medicare Total Advantage (HMO D-SNP) will cover behavioral health (mental health and addiction) services. You may have had some of these services before and now you can use your VillageCareMAX Medicare Total Advantage plan card to get these services. The services your plan will cover now include:

### **Adult Outpatient Mental Health Care**

- **Continuing Day Treatment (CDT):** Provides seriously mentally ill adults with the skills and supports necessary to remain in the community and be more independent. You can attend several days per week with visits lasting more than an hour.
- **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.

### **Adult Outpatient Rehabilitative Mental Health Care**

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community.
- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

### **Adult Outpatient Rehabilitative Mental Health And Addiction Services For Members Who Meet Clinical Requirements. These are also known as CORE**

- **Community Oriented Recovery and Empowerment (CORE) Services:** Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer or self-refer to CORE Services.
- **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources.
- **Community Psychiatric Supports and Treatment (CPST):** This service helps you manage symptoms through counseling and clinical treatment.
- **Empowerment Services – Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:
  - live with health challenges and be independent,
  - help you make decisions about your own recovery, and

find natural supports and resources.

- **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.

### **Adult Mental Health Crisis Services**

- **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.
- **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.
- **Crisis Residential Programs:** A short term residence that provides 24 hours per day services up to 28 days, for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support the return to your community.

### **Adult Outpatient Addiction Services**

- **Opioid Treatment Centers (OTP)** are OASAS certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

### **Adult Residential Addiction Services**

- **Residential Services** are for people who are in need of 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.

### **Adult Inpatient Addiction Rehabilitation Services**

- **State Operated Addiction Treatment Center's (ATC)** provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.
- **Inpatient Addiction Rehabilitation** programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.
- **Inpatient Medically Supervised Detox** programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services

you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.

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## **SECTION 6      What Medicaid Services are not Covered by VillageCareMAX Medicare Total Advantage Plan?**

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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.

<b>Service</b>	<b>Description</b>
<b>Assisted Living Program</b>	Provides personal care, housekeeping, supervision, home health aides. Personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services and the case management services of a registered professional nurse. Services are provided in an adult home or enriched housing setting.
<b>Directly Observed Therapy (DOT) for Treatment of Tuberculosis</b>	Services are covered through Medicaid Fee for Service, which include direct observation of oral ingestion of TB medications to ensure compliance with prescribed medication.
<b>Family Planning</b>	Services are covered through Medicaid Fee for Service, which include medical treatment such as vasectomies or tubal ligation.  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).
<b>Hospice Care</b>	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.
<b>Medicaid-covered Prescription Drugs</b>	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.

Service	Description
<b>Office for People with Developmental Disabilities</b>	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.
<b>Other Medicaid Services</b>	<p>The following services are covered through Medicaid Fee-for-Service:</p> <ul style="list-style-type: none"> <li>• Comprehensive Medicaid Case Management</li> <li>• Community Support Services</li> <li>• Home and Community Based Waiver Program Services</li> <li>• Rehabilitation services provided to residents of OMH licensed Community Residences and Family Based Treatment Programs</li> </ul>

***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
- Conversion or Reparative Therapy: any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.
- 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.

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## **SECTION 7      How Do I Get the Services That I Need? Service Authorizations, Actions, Appeals and Complaints**

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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.

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 253 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
<p><b>Adult Day Health Care</b></p> <p>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 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>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 your provider in obtaining doctor's orders if needed.</p> <p>Prior authorization is required from VillageCareMAX</p>
<p><b>Audiology/Hearing Aids not covered by Medicare</b></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><b>Consumer Directed Personal Assistance</b></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>



Service	Coverage Rules
<p><b>Dental</b></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</p> <p>Prior authorization may be required from VillageCareMAX.</p>
<p><b>Durable Medical Equipment (DME) not covered by Medicare</b></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><b>Home-Delivered Meals and/or Meals in a Group Setting</b></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><b>Home Health Care Services Not Covered by Medicare</b></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><b>Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit</b></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><b>Medical Social Services</b></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><b>Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies</b></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><b>Non-emergency Transportation</b></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><b>Nursing Home Care not covered by Medicare</b></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><b>Nutrition Services/Counseling</b></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><b>Optometry/Eyeglasses</b></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><b>Outpatient Mental Health &amp; Substance Abuse</b></p> <p>Services to treat mental health and substance abuse conditions in an outpatient setting.</p>	<p>You must get outpatient mental health &amp; 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 required for certain services, electroconvulsive therapy (ECT), and neuropsychological testing.</p>
<p><b>Personal Care</b></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><b>Personal Emergency Response Systems (PERS)</b></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><b>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home</b></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. VillageCareMAX will assist</p>

Service	Coverage Rules
<p><b>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home (continued)</b></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 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><b>Podiatry services not covered by Medicare</b></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><b>Private Duty Nursing</b></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><b>Prosthetics, Orthotics and Orthopedic Footwear</b></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 your provider in obtaining doctor's orders if needed.</p>

Service	Coverage Rules
<p><b>Prosthetics, Orthotics and Orthopedic Footwear (continued)</b></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>Prior authorization is required from VillageCareMAX.</p>
<p><b>Respiratory Therapy</b></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><b>Social and Environmental Supports</b></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><b>Social Day Care</b></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><b>Telehealth</b></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</p>	<p>Telehealth can be received to support covered services only.</p> <p>Prior authorization is required from VillageCareMAX.</p>

Service	Coverage Rules
<b>Telehealth (continued)</b>  recorded health history through a secure electronic communications system; and use of mobile devices to provide supportive services.	
<b>Veteran's Home Services</b>  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.

### 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](http://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](http://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.**

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## SECTION 9      Can I Leave the Plan?

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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.

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## **SECTION 10      What are my Rights and Responsibilities?**

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- ✓ 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 Local Department of Social Services.
- ✓ 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](http://icannys.org). When ICAN contacts VillageCareMAX on your behalf, we will work with ICAN to help you.



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## SECTION 11      Money Follows the Person (MFP) Program /Open Doors

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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 [mfpl@health.ny.gov](mailto:mfpl@health.ny.gov). You can also visit MFP/Open Doors on the web at [www.health.ny.gov/mfp](http://www.health.ny.gov/mfp) or [www.ilny.org](http://www.ilny.org)

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## SECTION 12      Notice of Non-discrimination

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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](mailto: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](http://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 <http://www.hhs.gov/ocr/office/file/index.html>.  
Phone: 1-800-368-1019, 800-537-7697 (TDD)

<b>Method</b>	<b>Member Services – Contact Information</b>
<b>CALL</b>	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.
<b>TTY</b>	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.
<b>FAX</b>	1-212-337-5711
<b>WRITE</b>	VillageCareMAX 112 Charles Street, New York, NY 10014
<b>WEBSITE</b>	<a href="http://www.villagecaremax.org">www.villagecaremax.org</a>

**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	Contact Information
<b>CALL</b>	1-800-701-0501 Calls to this number are free. Monday through Friday, 9:00 am to 4:00 pm
<b>TTY</b>	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. Monday through Friday, 9:00 am to 4:00 pm
<b>WRITE</b>	Health Insurance Information, Counseling and Assistance Program (HIICAP) 2 Lafayette Street, 9 <sup>th</sup> Floor New York, NY 10007-1392
<b>WEBSITE</b>	<a href="https://aging.ny.gov/health-insurance-information-counseling-and-assistance">https://aging.ny.gov/health-insurance-information-counseling-and-assistance</a>

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