January 1 – December 31, 2024

Evidence of Coverage:

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. **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 call is free.

This plan, *VillageCareMAX Medicare Total Advantage Plan*, 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 Plan (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, 2025.

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 DSNP 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.

OMB Approval 0938-1051 (Expires: February 29, 2024)

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 quí vị cần thông dịch viên xin gọi 1-800-469-6292 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-469-6292. 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ございます。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。

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

OMB Approval 0938-1051 (Expires: February 29, 2024)

SECTION 1 Introduction

Section 1.1 You are enrolled in *VillageCareMAX Medicare Total Advantage Plan,* which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

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

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, *VillageCareMAX Medicare Total Advantage Plan*. 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 Plan 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 Plan* 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 Plan* 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 Plan 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 Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage, long-term care and home and community-based services.

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

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

This *Evidence of Coverage* document tells you how to get your Medicare and Medicaid medical care , long-term care and home and community-based services 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 words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of *VillageCareMAX Medicare Total Advantage Plan*.

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 Plan* 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 Plan* between January 1, 2024, and December 31, 2024.

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 Plan* after December 31, 2024. 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, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve *VillageCareMAX Medicare Total Advantage Plan* 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.

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

Section 2.1 Your eligibility requirements

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

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

Section 2.2 What is Medicaid?

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

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

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

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

VillageCareMAX Medicare Total Advantage Plan 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.

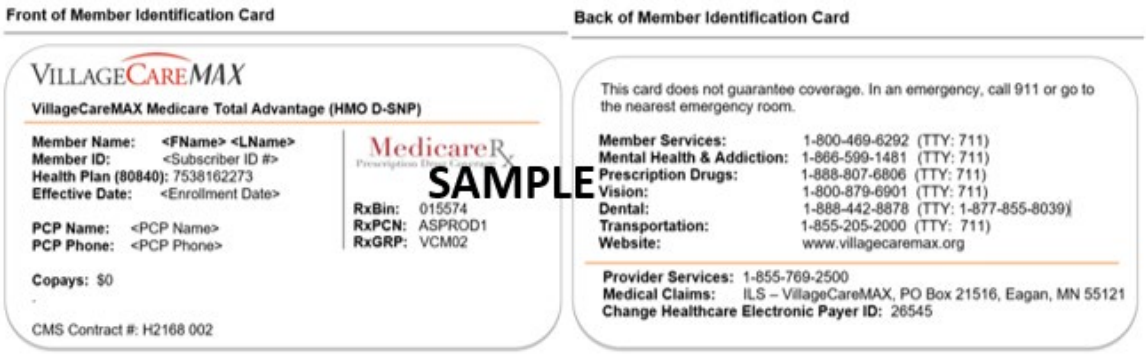
Section 2.4 U.S. Citizen or Lawful Presence

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 Plan* if you are not eligible to remain a member on this basis. *VillageCareMAX Medicare Total Advantage Plan* must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

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:



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 Plan* 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 current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and 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 Plan* 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 most recent list of providers and suppliers is available on our website at www.villagecaremax.org.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

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 Plan.* 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 Plan* "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) or call Member Services.

SECTION 4 Your monthly costs for VillageCareMAX Medicare Total Advantage Plan

Your costs may include the following:

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

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for *VillageCareMAX Medicare Total Advantage Plan.*

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 Plan* 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 4.3 Part D Late Enrollment Penalty

Because you are dually-eligible, the LEP doesn't apply to you as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. 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.

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.
    - **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 2024, this average premium amount is $34.70.
- 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 $34.70, which equals $4.86. This rounds to $4.90. 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.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, 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.

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).

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

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.

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner'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.

SECTION 7 How other insurance works with our plan

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.
- 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 or domestic partner 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

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

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 Plan Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-800-469-6292 Calls to this number are free. 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.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available seven day a week from 8:00 am to 8:00 pm.
FAX	1-212-337-5711
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014 Email: vcmaxmembers@villagecare.org
WEBSITE	wwww.villagecaremax.org

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)*).

Method	Coverage Decisions and Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	1-800-469-6292 Calls to these numbers 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.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm
FAX	1-212-337-5711 (*Coverage Decisions*) 1-347-226-5180 (*Appeals*)
WRITE	VillageCareMAX 112 Charles Street, New York, NY 10014
WEBSITE	www.villagecaremax.org

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

You can make a complaint about us or one of our network providers 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)*).

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

Where to send a request asking us to pay 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 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.

Method	Payment Requests – Contact Information
CALL	1-800-469-6262 Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available seven days a week from 8:00 am to 8:00 pm.
FAX	212-337-5711
WRITE	VillageCareMAX 112 Charles Street New York NY 10014
WEBSITE	www.villagecaremax.org

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes 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: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about *VillageCareMAX Medicare Total Advantage Plan*: • **Tell Medicare about your complaint:** You can submit a complaint about *VillageCareMAX Medicare Total Advantage Plan* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. 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.)

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

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

Health Insurance Information, Counseling and Assistance Program (HIICAP) is 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. Health Insurance Information, Counseling and Assistance Program (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.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	Health Insurance Information, Counseling and Assistance Program (New York HIICAP) – Contact Information
CALL	1-800-701-0501 Calls to this number are free. Available Monday through Friday, 9:00 am to 4:00 pm
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available Monday through Friday, 9:00 am to 4:00 pm
WRITE	Health Insurance Information, Counseling and Assistance Program (New York HIICAP) 2 Lafayette Street, 9th Floor New York, NY 10007-1392
WEBSITE	https://aging.ny.gov/health-insurance-information-counseling-and-assistance

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
CALL	1-866-815-5440 Calls to this number are free. Available Monday through Friday from 9:00 am to 5:00 pm, and Saturday through Sunday from 11:00 am to 3:00 pm. Fax: 1-855-236-2423
TTY	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.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	https://www.livantaqio.com/en/states/new_york

SECTION 5 Social Security

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

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

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 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.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. Below is the Medicare Savings Program eligible to enroll in VillageCareMAX Medicare Total Advantage Plan.

- **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 Plan* is a Dual Eligible Special Needs Plan (D-SNP) that covers your Medicare coverage while you receive Medicaid benefits under the New York State Medicaid program. VillageCareMAX also contract with the state to provide a dual-eligible individual with long-term care services and supports.

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

Method	New York State Department of Health Medicaid Helpline – Contact Information
CALL	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.
TTY	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.
WRITE	Medicaid@health.ny.gov
WEBSITE	https://www.health.ny.gov/health_care/medicaid/

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
CALL	1-844-614-8800 Calls to this number are free Available Monday through Friday from 9:00 am to 5:00 pm
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free Available Monday through Friday from 9:00 am to 5:00 pm
WRITE	Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 633 Third Ave, 10th Floor New York NY 10017
WEBSITE	www.icannys.org

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
CALL	1-855-582-6769 Calls to this number are free Available: 9:00 am to 5:00 pm, Monday through Friday
WRITE	Long Term Care Ombudsman Program Two Empire State Plaza Albany, New York NY 12223-1251
WEBSITE	www.ltcombudsman.ny.gov

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

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-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 8 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 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 the 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).

Method	Elderly Pharmaceutical Insurance Coverage (EPIC) (New York's State Pharmaceutical Assistance Program) – Contact Information
CALL	1-800-332-3742 Calls to this number are free Available Monday through Friday from 8:30am to 5:00pm
TTY	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
WRITE	EPIC P.O. Box 15018 Albany, NY 12212-5018
WEBSITE	www.health.ny.gov/health_care/epic

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you 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.

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

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse or domestic partner'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 or domestic partner'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

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

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

Section 1.1 What are network providers and covered services?

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment 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 pay 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.

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

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

VillageCareMAX Medicare Total Advantage Plan 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.

- **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 or Medicaid 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 at no cost to you. 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.

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

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

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.

What is 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 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 immediately. We will update your membership record with the PCP information and mail you a new Member ID card. The name and office phone number of your PCP will be printed on your Member ID card.

Changing your PCP

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

To change your PCP, call Member Services to request a new PCP (contact information is on the back cover of this document). Member Services will check to see if the PCP is accepting new patients. The change in PCP will be effective immediately, but your new membership card may take 7-10 business days to arrive. The new Member ID card will show the new PCP name and office phone number.

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 transition period for you to continue to receive services from the provider who is leaving the network until you complete your current course of treatment.

Section 2.2 What kinds of medical care and other services can you get without a referral from your PCP?

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.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. 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 in the plan's network. 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 notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. You must get prior authorization from the plan prior to seeking care.

- 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.

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

- 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 authorization 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.*

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

Section 3.1 Getting care if you have a medical emergency

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 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, as well as worldwide emergency and urgent care coverage, and from any provider with an appropriate state license even if they are not part of our network.

- **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?

Our plan covers emergency and urgently need care, including emergency transportation received outside of the United States and its territories. Medicare does not provide emergency/urgent coverage outside the United States and its territories. Please see the Medical Benefits Chart in Chapter 4 for more information.

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:

- If you need emergency transportation to get care
- To furnish emergency services, and needed urgent 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.villagecare.com 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.

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

Section 4.1 You can ask us to pay for covered services

If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

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

VillageCareMAX Medicare Total Advantage Plan 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 Total Advantage Plan* 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 Plan* has an annual Maximum Out-of-Pocket limit of $8,850. Once a benefit limit has been reached, your out of pocket costs will not count toward your out-of-pocket maximum 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.

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

Section 5.1 What is a clinical research study?

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

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. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, 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*.

Section 5.2 When you participate in a clinical research study, who pays for what?

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 rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

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.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we 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).

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you 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. The Plan covers unlimited coverage for this benefit when medically necessary. Please see the Benefits Chart in Chapter 4 for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

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 Plan,* 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 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.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage *VillageCareMAX Medicare Total Advantage Plan* 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 Plan* 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)

SECTION 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of *VillageCareMAX Medicare Total Advantage Plan*. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered services

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

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

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. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $8,850.

The amounts you pay for deductibles, 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 $8,850, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

Section 2.1 Your medical benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services *VillageCareMAX Medicare Total Advantage Plan* 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 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

- *VillageCareMAX Medicare Total Advantage Plan* 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 continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost 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 of these chronic conditions, require intense care coordination, and be 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 are 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
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	There is no coinsurance, copayment, or deductible for members eligible for acupuncture for chronic low back pain services. *Prior Authorization is required from VillageCareMAX for Acupuncture for chronic low back pain

Services that are covered for you	**What you must pay** when you get these services
Acupuncture for chronic low back pain* (continued) Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. 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: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. 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. You are covered for additional acupuncture visits: • You are covered for up to 54 visits per year with a maximum of 5 visits per month (up to $80 limit per visit). • Services must be provided by a certified and licensed provider in the VillageCareMAX network.	

Services that are covered for you	**What you must pay** when you get these services
Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care 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. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	There is no coinsurance, copayment, or deductible for Medicare covered acupuncture visits. * Prior Authorization may be required from VillageCareMAX for certain services.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your 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.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement 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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	**What you must pay** when you get these services
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. 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 • Cardiac rehabilitation services, and • Intensive cardiac rehabilitation services *Prior Authorization is required from VillageCareMAX for Cardiac rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing 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.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • 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	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services* Covered services include: We cover only manual manipulation of the spine to correct subluxation	There is no coinsurance, copayment, or deductible for Medicare covered chiropractic services. *Prior Authorization is required from VillageCareMAX for Chiropractic services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and subject to copay/coinsurance. There is no coinsurance, copayment, or deductible for a Medicare-covered Barium Enema.

Services that are covered for you	**What you must pay** when you get these services
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: **Additional dental benefits covered by VillageCareMAX*** Comprehensive dental services: • You are covered for up to $2,000 ($1000 per every 6-months) 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. • This benefit is limited to the dental procedure codes covered by the plan. Age restrictions may apply. o Crowns, retainer crowns, and pontics (false teeth) are limited to 1 per tooth every 60 months o Resin-based composite (fillings) are limited to 1 per surface per tooth every 36 months o Endodontic services (root canal therapy) are limited to 1 per tooth in a lifetime o Periodontics (treatment of gum disease) are limited to 1 per site/quad every 24 months o Palliative (emergency) treatment/minor procedure limited to 1 every 12 months o House/extended care facility call limited to 1 every 6 months o Teledentistry services limited to 2 every calendar year o Extractions, non-routine and diagnostic services	There is no coinsurance, copayment, or deductible for dental services *Prior Authorization may be required from VillageCareMAX for certain dental services from Liberty Dental (dental vendor)

Services that are covered for you	**What you must pay** when you get these services
Dental services* (continued) Unused amounts from the biannual limit carry over and must be used by December 31, 2024. VillageCareMAX uses a vendor called Liberty Dental to help manage the coverage of Dental benefits and services. For Dental-related information, call Liberty Dental at 1-888-442-8878 (TTY: 1-877-855-8039), from 8:00 am to 8:00 pm, 7 days a week.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening 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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic 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. • Diabetes self-management training is covered under certain conditions. Abbott is the preferred manufacturer for blood glucose, glucometers and testing supplies.	There is no coinsurance, copayment, or deductible for Medicare-covered services: • Diabetic monitoring supplies • Diabetic therapeutic shoes or inserts. • Diabetes self-management training services. *Prior Authorization is required from VillageCareMAX is for certain services/items.
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.villagecare.org. ***The plan also covers Medicaid-covered DME and related supplies. See Chapter 13 for more information.***	There is no coinsurance, copayment, or deductible for Medicare-covered durable medical equipment and supplies. *Prior Authorization is required from VillageCareMAX for certain services/items.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **Additional benefits covered by VillageCareMAX:** 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. ***See "Worldwide Emergency/Urgent Coverage" in this chart for additional coverage.***	There is no coinsurance, copayment, or deductible for emergency care. 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 *OR* 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. You pay nothing for covered Worldwide Emergency Care.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs You are covered for: • Fitness membership through the Silver&Fit Healthy Aging and Exercise program: o Access to fitness centers within the network o Home fitness kits if you prefer to work out at home o Coaching via telephone 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. For more information about this benefit you can visit the web site www.SilverandFit.com or call toll free 1.877.427.4788 (TTY/TDD: 711), Monday through Friday, 8 a.m. to 9 p.m. Eastern time	There is no coinsurance, copayment, or deductible for: • Fitness membership • Health and wellness education programs
Hearing services 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. ***The plan also covers Medicaid-covered Hearing services.*** ***See Chapter 13 for more information.***	There is no coinsurance, copayment, or deductible for each Medicare-covered exam to diagnose and treat hearing and balance issues. *Prior Authorization is required from VillageCareMAX for hearing aids. .
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Services that are covered for you	**What you must pay** when you get these services
Home health agency care 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. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	There is no coinsurance, copayment, or deductible for Medicare-covered home health services. *Prior Authorization is required from VillageCareMAX for home health services.
Home infusion therapy* 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). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	There is no coinsurance, copayment, or deductible for each Medicare-covered home infusion therapy service. *Prior Authorization is required from VillageCareMAX for home infusion therapy services.

Services that are covered for you	**What you must pay** when you get these services
Hospice care 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. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: 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.	There is no coinsurance, copayment, or deductible for hospice care. 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 Plan.*

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: 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). • 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 • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by *VillageCareMAX Medicare Total Advantage Plan* but are not covered by Medicare Part A or B: *VillageCareMAX Medicare Total Advantage Plan* 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. For drugs that may be covered by the plan's Part D benefit: 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 (*What if you're in Medicare-certified hospice*). **Note:** 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
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	There is no coinsurance, copayment, or deductible for Medicare-covered inpatient hospital care *Prior Authorization is required from VillageCareMAX for inpatient hospital services.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care* (continued) • 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 • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. 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 https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	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. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay. o You are covered for up to 190 days for inpatient services in a free-standing psychiatric hospital. o The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Additional days beyond the 190-day lifetime limit are covered through Medicaid. See Chapter 13 for more information. 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	There is no coinsurance, copayment, or deductible for covered inpatient mental health care. *Prior Authorization is required from VillageCareMAX for inpatient psychiatric care.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay* 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: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	There is no coinsurance, copayment, or deductible for covered inpatient mental health care. *Prior authorization is required from VillageCareMAX for certain services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during 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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	**What you must pay** when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • 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 • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Part B and Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for Medicare Part B prescription drugs *Prior authorization is required from VillageCareMAX for certain injectable drugs

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs* (continued) 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.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services* 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: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	There is no coinsurance, copayment, or deductible for Medicare-covered opioid treatment program services. *Prior Authorization is required from VillageCareMAX for Opioid Treatment Program Services

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	There is no coinsurance, copayment, or deductible for Medicare-covered: • X-rays • Diagnostic and therapeutic radiological services • Laboratory tests • Medical and surgical supplies *Prior authorization is required from VillageCareMAX for certain services.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet 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. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.	There is no coinsurance, copayment, or deductible for Medicare-covered outpatient hospital observation.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital observation (continued) 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 https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	There is no coinsurance, copayment, or deductible for Medicare-covered outpatient hospital services. *Prior authorization is required from VillageCareMAX for certain services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. For behavioral- and mental health-related information, call Carelon Behavioral Health at 1-866-599-1481 (TTY: 711), 8 am – 6 pm, Monday – Friday	There is no coinsurance, copayment, or deductible for each Medicare-covered individual or group therapy session.
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	There is no coinsurance, copayment, or deductible for each Medicare-covered: • Physical Therapy visits • Occupational Therapy visits • Speech Language Therapy visits *Prior authorization is required from VillageCareMAX for outpatient rehabilitation services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services* Covered services include, but are not limited to: • Individual and group sessions for counseling or therapy • Treatment of inappropriate alcohol and drug use • Family counseling as needed to help with treatment Substance abuse program services that provide individualized plan of care with interventions to reduce/eliminate the use of alcohol and/or other substances	There is no coinsurance, copayment, or deductible for each Medicare-covered individual and group therapy session. *Prior Authorization is required from VillageCareMAX for outpatient substance abuse services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	There is no coinsurance, copayment, or deductible for each Medicare-covered: • Ambulatory Surgical Center visit • Outpatient Hospital services *Prior Authorization is required from VillageCareMAX for certain outpatient surgery services.

Services that are covered for you	**What you must pay** when you get these services
Over-the-counter items As a member of VillageCareMAX , you receive an Over-the-Counter (OTC) card with a monthly amount for plan-approved items. • You are covered for up to $3,000 per year ($250 per month) on your OTC card to buy approved non-prescription drugs and health-related items at participating locations or online for home delivery**.** • Any unused balance will carry over month to month but must be used by the end of the 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 credit card and cannot be converted to cash • Some items are labeled "Dual Purpose" and can only be purchased if recommended by your doctor • Some OTC items may be available to you through Medicaid when you use your Medicaid ID card You can visit our website at www.villagecaremax.org or contact Member Services for a comprehensive listing of approved items and more details about how to activate and use your OTC card ***See "Special Supplemental Benefits for the Chronically Ill (SSBCI) – Food, Produce & Utilities" in the medical chart.***	You are covered for up to $3,000 per year ($250 per month) on your OTC card to buy approved non-prescription drugs and health-related items at participating locations. Eligible members can also use their monthly benefit amount to get COVID-19 Tests, Nicotine Replacement Therapy & OTC Hearing Aids, Food, Produce (grocery items), and pay for Utilities: Gas/Electric/Fuel Oil, Water/Sanitary/Sewer, Internet/Telecommunications. OTC items must be purchased from participating providers The unused funds carry over from month to month but must be used by the end of the year.

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services and Intensive outpatient services 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. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	There is no coinsurance, copayment, or deductible for Medicare-covered Partial hospitalization services. *Prior Authorization is required from VillageCareMAX for partial hospitalization services.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits* Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment Certain telehealth services, including: Skilled Nursing Facility (SNF);Partial Hospitalization, Home Health Services, Glaucoma Screening, Diabetes Self-Management Training, Cardiac Rehabilitation Services, Intensive Cardiac Rehabilitation Services, Pulmonary Rehabilitation Services, SET for PAD Services, Individual and Group Sessions for Mental Health Specialty Services, Kidney Diseases Education Services, Eye Exams, Hearing Exams, Primary Care Physician Services, Chiropractic Services, Occupational Therapy Services, Physician Specialist Services, Podiatry Services; Lab 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, and Individual and Group Sessions for Outpatient Substance Abuse. ○ 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. ○ 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.	There is no coinsurance, copayment, or deductible for each Medicare-covered Primary Care Provider (PCP) or Specialist visit. *Prior Authorization is required from VillageCareMAX for certain non-routine procedures.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o 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**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o 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**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o 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	

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • 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)	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	There is no coinsurance, copayment, or deductible for each Medicare-covered visit for podiatry services. Medicare-covered podiatry services are for medically necessary foot care.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	There is no coinsurance, copayment, or deductible for Medicare-covered: • Prosthetic devices • Medical supplies *Prior authorization is required from VillageCareMAX for certain prosthetic devices and medical supplies.
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	There is no coinsurance, copayment, or deductible for each Medicare-covered pulmonary rehabilitation services. *Prior authorization is required from VillageCareMAX for pulmonary rehabilitation services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who 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. *For LDCT lung cancer screenings after the initial LDCT screening:* 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.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease Covered services include: • 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 • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) 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**.	There is no coinsurance or copayment for Medicare-covered services for dialysis and to treat kidney disease and conditions. Network providers do not require an authorization-but notification is preferred. Out of network providers require authorization. .

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) You are covered for 100 days per benefit period for Medicare-covered SNF stays. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services 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. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	There is no coinsurance, copayment, or deductible for covered skilled nursing facility care. 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. *Prior Authorization is required from VillageCareMAX for skilled nursing facility services

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: 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. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: 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. ***See Over the Counter (OTC) Items in this medical chart for more information about over-the-counter smoking cessation items***	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Special Supplemental Benefits for the Chronically Ill **Food, Produce (Grocery Items) & Utilities** Members with chronic conditions who meet certain criteria are eligible for Food**,** Produce (Grocery Items)**, & Utilities. (**Eligible members can use their OTC card to get grocery items (in addition to health-related items). Utilities included but not limited to: o Gas/Electric/Fuel Oil o Water/Sanitary/Sewer o Internet/Telecommunications • **There is a combined maximum amount of $250 monthly ($3,000 per year) over-the-counter health related items, Food & Produce, and Utilities** • Any unused balance will carry over month to month but will expire at the end of the year.	There is no coinsurance, copayment, or deductible for OTC products and grocery items. You can visit our website at www.villagecaremax.org or contact Member Services for a comprehensive listing of approved items and more details about how to activate and use your OTC card.

Services that are covered for you	**What you must pay** when you get these services
Special Supplemental Benefits for the Chronically Ill **Food, Produce (Grocery Items) & Utilities (continued)** • 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 credit and cannot be converted to cash Food, Produce (grocery items) & Utilities 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. • 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 **Special Supplemental Benefits for the Chronically Ill** **Food, Produce (Grocery Items) & Utilities (continued)** • Upon enrollment, VillageCareMAX will help determine if you meet the criteria and eligible to receive the grocery and utilities benefit. • The benefits mentioned are a part of Special Supplemental program for the Chronically Ill. Not all members will qualify. ***See Over the Counter (OTC) Items in this medical chart for more information about how this combined benefit works***	

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques 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.	There is no coinsurance, copayment, or deductible for Medicare-covered Supervised Exercise Therapy (SET). *Prior authorization is required from VillageCareMAX for Supervised Exercise Therapy (SET).
Transportation services (non-emergency)* ***Plan covers Medicaid-covered unlimited transportation trips for medical needs. See Chapter 13 for more information.*** **Additional benefits covered by VillageCareMAX*:** • 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.	There is no coinsurance, copayment, or deductible for transportation trips. * Prior authorization is required from VillageCareMAX for non-emergency transportation services. Non-medical Transportation is limited to 6 round trips (12 one-way trips) per year

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services 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. 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. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Additional benefits covered by VillageCareMAX**: 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.***	There is no coinsurance, copayment, or deductible for each Medicare-covered urgently needed services

Services that are covered for you	**What you must pay** when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk 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 • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) **Additional benefits covered by VillageCareMAX***: • One (1) routine eye exam every year • Up to $350 every year for contact lenses or eyeglasses (lenses and frames) with a **limit**. o contacts (unlimited) o eyeglasses (lenses + frames) - 1 per year o lenses (1 pair per year) o frames (1 per year) ***The plan also covers Medicaid-covered vision services. See Chapter 13 for more information.***	There is no coinsurance, copayment, or deductible for the additional vision benefits covered by VillageCareMAX plan *Prior authorization may be required form VillageCareMAX for vision care.

Services that are covered for you	**What you must pay** when you get these services
Welcome to Medicare preventive visit 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. **Important:** 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.	There is no coinsurance, copayment, or deductible for the **Welcome to Medicare** preventive visit.
Worldwide Emergency/Urgent Coverage 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. 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. 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.	$0 copay for each emergency care visit worldwide. Worldwide ER services cost sharing is not waived if you are admitted to the hospital for the same condition. $0 copay for each urgent care visit worldwide. Worldwide urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition. $0 copay for each emergency/urgent transportation service worldwide. Worldwide transportation services cost sharing is not waived if you are admitted to the hospital for the same condition.

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

Section 3.1 Services *not* covered by VillageCareMAX Medicare Total Advantage Plan

The following services are not covered by VillageCareMAX Medicare Total Advantage Plan 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.

SECTION 4 What services are not covered by the plan?

Section 4.1 Services *not* covered by the plan (exclusions)

This section tells you what services are excluded.

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 and for routine visits (see the Medical Benefits chart in Section 2.1 of this chapter).

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care. Custodial care is personal care that 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.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	
Home-delivered meals	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
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.	**Not covered under any condition**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	**Not covered under any condition**	• 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 considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	

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.)

SECTION 1 Introduction

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.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write 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 references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider* and *Pharmacy Directory*, visit our website (www.villagecaremax.com), and/or call Member Services.

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 Provider and Pharmacy Directory*. You can also find information on our website at www.villagecaremax.com.

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 *Provider and Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order service

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 long-term medical condition.

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

To get information about filling your prescriptions by mail, please review the mail order forms included in your Welcome Packet. You can also contact 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.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by registering online at medimpact**.**com. You need to provide your information, including your allergies, medical conditions, contact information and shipping address. Your doctor will need to submit a 90-day-supply prescription to Birdi to start the home delivery service.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by signing in to medimpact.com or MedImpact mobile app or call Birdi toll-free at 1-855-873-8739 (TTY dial 711) to opt out of Auto fill.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill MedImpact Direct Mail®, serviced by Birdi pharmacy. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our MedImpact Direct Mail®, serviced by Birdi pharmacy that automatically prepares mail-order refills, please contact us by signing in to medimpact.com or MedImpact mobile app or calling Birdi toll-free at 1-855-873-8739 (TTY dial 711) to opt out of Auto refill.

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

Section 2.4 How can you get a long-term supply of drugs?

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. 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.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

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. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list 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. For more information about your Medicaid drug coverage, contact the New York State Medicaid Pharmacy clinical call center at 1-877-309-9493 or visit the website at www.health.ny.gov/health_care/medicaid/program/pharmacy.htm.

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

- Approved by the Food and Drug Administration 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, generic drugs, and biosimilars.

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. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

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).

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.

- The Drug List does not include drugs covered by Medicaid. For more information about your Medicaid drug coverage, contact the New York State Medicaid Pharmacy clinical call center at 1-877-309-9493 or visit the website at www.health.ny.gov/health_care/medicaid/program/pharmacy.htm

Section 3.2 There are *5* cost-sharing tiers for drugs on the "Drug List"

Every drug on the plan's "Drug List" is in one of *5* cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Tier 1, the Preferred Generic tier, is the lowest cost tier. Tier 5, the Specialty tier, is the highest cost tier.

- **Tier 1 - Preferred Generic:** includes the most commonly prescribed generic drugs, generally at the lowest cost.
  - You pay $6 per month supply for each covered insulin product on this tier.
- **Tier 2 -Generic:** includes drugs that have the same active ingredients as the brand-name drugs, but usually cost less than brand-name versions.
  - You pay $12 per month supply for each covered insulin product on this tier.
- **Tier 3 - Preferred Brand:** includes brand-name drugs that may not be available in generic form but are cost effective compared to non-preferred brand drugs.
  - You pay $35 per month supply for each covered insulin product on this tier.
- **Tier 4 - Non-Preferred Drug:** includes brand-name and generic drugs that are generally more expensive than preferred medications.
  - You pay $35 per month supply for each covered insulin product on this tier.
- **Tier 5 - Specialty Tier:** includes high-cost drugs used to treat complex conditions and may require monitoring. They can be generic or brand name.

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

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

Section 3.3 How can you find out if a specific drug is on the "Drug List"?

You have 4 ways to find out:

1. Check the most recent "Drug List" we sent you in the mail.
2. Visit the plan's website(www.villagecaremax.com). 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.
4. Use the plan's "Real-Time Benefit Tool" (www.villagecaremax.org) or by calling Member Services). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to 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).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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 or original biological products when a generic *:* or interchangeable biosimilar version is available

Generally, a "generic" drug *or interchangeable biosimilar* works the same as a brand name drug *or original biological product* and usually costs less. **In most cases, when a generic *or interchangeable biosimilar* version of a brand name drug *or original biological product* is available, our network pharmacies will provide you the generic *or interchangeable biosimilar* version instead of the brand name drug *or original biological product***. However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar

will not work for you *OR* has written "No substitutions" on your prescription for a brand name drug or original biological product *OR* has told us the medical reason that neither the generic drug , interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

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.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

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

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:

- 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.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

- 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 in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.
- 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.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

If your drug is not on the "Drug List" or is restricted, here are 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 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days 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 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 Plan 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.

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.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call 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.

You can ask for an exception

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

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

Drugs in our Tier 5 - Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier

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

Section 6.1 The "Drug List" can change during the year

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

- **Add or remove drugs from the "Drug List."**
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**
- Replace an original biological product with an interchangeable biosimilar version of the biological product

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

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the "Drug List" occur, 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.
    - 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.
- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List." If you are taking that drug, we will tell you right away.
    - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
    - We may make other changes once the year has started that affect drugs you are taking. For 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.

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

Section 7.1 Types of drugs we do not cover

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 by our plan is also excluded by Medicaid, you must pay for it yourself. (except for certain excluded drugs covered under our enhanced drug coverage).

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

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's "Drug List" or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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 your drug.

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

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, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you**. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

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

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

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

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

Check your *Provider and 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.

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

If you currently have other prescription drug coverage through your (or your spouse or domestic partner'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.

Section 9.4 What if you're in Medicare-certified hospice?

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 drugs, laxatives, pain medication or anti-anxiety 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.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several 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 may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain 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 tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. 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 decision 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 new 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.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure 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. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will 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.

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.

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

Section 11.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the Part D EOB)

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 Costs**.
- 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 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.

Section 11.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here 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 your out-of-pocket costs, give us copies of your 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."

CHAPTER 7:

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

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

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

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called **reimbursing** you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. 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 paid and 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. 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. 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.

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 "Drug List" or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

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 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.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 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. We need the following information to make a decision:
    - ***Member Information*** – Name, Member ID, Address, Telephone

- ***Service Information*** – Type of Service, Date of Service, Provider's Name/Contact Information, Total Paid
- ***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) 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:

Medical Claims

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

Part D Prescription Drugs Claims

Mail your request for payment 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.

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

Section 3.1 We check to see whether we should cover the service or drug

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 the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or 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

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

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. This document is available for free 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 to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in 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 aquéllas con dominio limitado del inglés, aptitudes limitadas de lectura, incapacidad auditiva o aquéllas 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).

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。

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

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.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the **personal information** you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that 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 Plan,* 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.
- **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.

Section 1.5 We must support your right to make decisions about your care

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:

- 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.
- **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 New York State Department of Health:

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

Telephone Number: 1-800-541-2831.

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

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**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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 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).
- Or, **you can call New York State Department of Health Medicaid Helpline** at 1-800-541-2831 (TTY: 1-800-662-1220). Available Monday through Friday, 8:00 am to 5:00 pm, and Saturday from 9:00 am to 1:00 pm.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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.
  - 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 plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.

- **If you move *outside* 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)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

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

- For some 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.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people 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”, “coverage decision” rather than “integrated organization determination” or “coverage determination” or at-“risk determination”, and independent review organization instead of Independent Review Entity.
- 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.

SECTION 2 Where to get more information and personalized assistance

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).

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**:**

Method	New York State Department of Health Medicaid Helpline – Contact Information
CALL	1-800-541-2831 Available Monday through Friday, 8:00 am to 5:00 pm, and Saturday from 9:00 am to 1:00 pm.
TTY	1-800-662-1220 Available Monday through Friday, 8:00 am to 5:00 pm, and Saturday from 9:00 am to 1:00 pm.
WRITE	Medicaid@health.ny.gov
WEBSITE	https://www.health.ny.gov/health_care/medicaid/

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	Livanta (New York's Quality Improvement Organization) – Contact Information
CALL	1-866-815-5440 Available Monday through Friday from 9:00 am to 5:00 pm, and Saturday through Sunday from 11:00 am to 3:00 pm.
TTY	1-866-868-2289 Available Monday through Friday from 9:00 am to 9:00 pm, and Saturday through Sunday from 11:00 am to 3:00 pm.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	https://www.livantaqio.com/en/states/new_york

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

You have Medicare and get assistance from Medicaid. Information in this chapter applies to **all** of your Medicare and **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

SECTION 4 Coverage decisions and appeals

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

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."**

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

Section 5.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice

for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you.

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit 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 say no to all or part of your Level 1 appeal for medical care, 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.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

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

Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- 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 or on our website at 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 or on our website at www,villagecaremax.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person 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.

Section 5.3 Which section of this chapter gives the details for your situation?

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.

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

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered*). 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 Sections 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **"integrated organization determination.** A fast coverage decision is called an **expedited determination.**

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

A standard coverage decision is usually made within 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 items and/or services (not requests for payment for items and/or services already received).

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

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

If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision. If we 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. 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 11 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 11 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.

Section 6.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
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 or 7 days for Part B drugs. 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 10 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 when it receives your appeal.

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 the 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.

Section 6.4 Step-by-step: How a Level 2 appeal is done

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 may also continue during Level 2. Go to page 142 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.

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

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 covered. 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 medical care 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.

Section 6.6 External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only.**

You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- not medically necessary or
- experimental or investigational or
- not different from care you can get in the plan's network or
- available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services at 1-800-469-6292 (TTY: 711) if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov.
- Contact the health plan at 1-800-469-6292 (TTY: 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

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

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits 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 **coverage determination.**

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 pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **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.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the "Drug List" is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

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

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."**
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List". If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *5* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
    - If our "Drug List" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a brand name drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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. If you ask us for a tiering exception, we will generally **not** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of 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.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A "fast coverage decision" is called an "**expedited coverage determination."**

<u>Step 1:</u> 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 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 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.

Section 7.5 Step-by-step: How to make a Level 1 appeal

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.

Section 7.6 Step-by-step: How to make a Level 2 appeal

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

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 you are 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 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 you more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

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

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.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells you about your rights

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.

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.

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.

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at 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.

Section 8.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Term
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. 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 "**Independent Review Entity".** It is sometimes called the "**IRE".**

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.

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

Section 9.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term
"Notice of Medicare Non-Coverage." It tells you how you can request a "**fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

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 <u>not</u> mean you agree** with the plan's decision to stop care.

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **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*.
- 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
Detailed Explanation of Non-Coverage. 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.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

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

- You must ask for this review **within 60 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.

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

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 "**expedited 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 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 "**Independent Review Entity".** It is sometimes called the "**IRE."**

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.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service 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. 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.

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.

Level 3 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 3 decision that is favorable to you. We will decide whether to appeal this decision to Level 4.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you 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, the notice you get will tell you whether the rules allow you to go on to a Level 4 appeal and how to continue with a Level 4 appeal.

Level 4 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 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.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	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: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

- 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."**

Section 11.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- 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.
- **If you have a complaint,** you can tell us about it by phone or in writing. Contact information is listed in Chapter 2. We will investigate your concerns and notify you of a decision by telephone or writing (or both) as quickly as required based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension. The plan can also extend the timeframe if we justify a need for additional information and the delay is in your best interest. If an extension is taken, you will receive a letter with an explanation. You can also file an expedited (fast) complaint for any of the below situations. When you request a fast complaint, we will give you an answer by phone within 24 hours of receiving your complaint and mail a letter with an explanation of the decision within 3 calendar days.
    - You asked for a fast decision on a service or an appeal for a service, and we decided to process it under our regular (non-expedited) time frame
    - We need up to 14 more days to decide on your request for a service or an appeal for a service
- **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 because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **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.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

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.**

Section 11.5 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about *VillageCareMAX Medicare Total Advantage Plan* directly to Medicare. To submit a complaint to Medicare, go to 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

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in *VillageCareMAX Medicare Total Advantage Plan* 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.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to 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.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). 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.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

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.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

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):

- 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."

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Services.**
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from *VillageCareMAX Medicare Total Advantage Plan* when your new plan's coverage begins.
Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from *VillageCareMAX Medicare Total Advantage Plan* when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan o 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. o 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.	• **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *VillageCareMAX Medicare Total Advantage Plan* when your coverage in Original Medicare begins.

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.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership *VillageCareMAX Medicare Total Advantage Plan* ends, and your new Medicare coverage begins, you must continue to get your medical items, services 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).

SECTION 5 VillageCareMAX Medicare Total Advantage Plan must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

VillageCareMAX Medicare Total Advantage Plan 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 thirty (30) consecutive days
  - 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.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

VillageCareMAX Medicare Total Advantage Plan 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).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, 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.

SECTION 2 Notice about nondiscrimination

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.html.

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)
- 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

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)

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *VillageCareMAX Medicare Total Advantage Plan*, 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.

CHAPTER 12:
Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Benefit Period – The way that 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. . During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs 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.

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.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of *5* cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this 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.

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.

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 out-of-pocket costs for the year have reached $5,030.

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).

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. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. (**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.

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.

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 services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans 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.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – 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.

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who 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

Assistance is available 24 hours a day, 7 days a week. 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.

WELCOME TO VillageCareMAX Medicare Total Advantage Plan (HMO D-SNP), MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to VillageCareMAX Medicare Total Advantage Plan (HMO D-SNP), Medicaid Advantage Plus (MAP) Program. MAP combines Medicaid and Medicare coverage offered through VillageCareMAX Medicare Total Advantage Plan dba VillageCareMAX. The MAP Program is designed for people who have Medicare and Medicaid and who need health services and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible. You must choose one of the doctors from the plan to be your Primary Care Provider (PCP). If you decide later to change your Medicare plan, you will also have to leave VillageCareMAX Medicare Total Advantage Plan MAP.

This chapter/handbook tells you about the added benefits VillageCareMAX Medicare Total Advantage Plan covers since you are enrolled in the VillageCareMAX MAP Program. It also tells you how to request a service, file a complaint or disenroll from VillageCareMAX MAP Program. The benefits described in this chapter/handbook are in addition to the Medicare benefits described in Chapter 4 of this VillageCareMAX Medicare Total Advantage Plan Medicare Evidence of Coverage. Keep this chapter/handbook with the VillageCareMAX Medicare Total Advantage Plan Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

HELP FROM MEMBER SERVICES

You can call us at any time, 24 hours a day, seven days a week, at the Member Services number below.

There is someone to help you at Member Services:
7 days a week
8:00 am to 8:00 pm
Call 1-800-469-6292 (TTY: 711)

If you need assistance in another language, VillageCareMAX will provide you with staff or translation services to communicate with you in the language you speak. 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.

ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the MAP Program if you meet all of the following requirements:

1) Are age **18** and older,
2) Reside in the plan's service area, which is Bronx, Kings (Brooklyn), New York (Manhattan), and Queens. Nassau*, Richmond* (Staten Island), and Westchester*
***upon approval from New York State Department of Health*

3) Have Medicaid,
4) Have evidence of Medicare Part A & B coverage,
5) Are eligible for nursing home level of care (as of time of enrollment) using the Community Health Assessment (CHA),
6) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety,
7) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the Medicaid Advantage Plus Plan for more than 120 days from the effective date of enrollment:
    a. Nursing services in the home
    b. Therapies in the home
    c. Home health aide services
    d. Personal care services in the home
    e. Adult day health care,
    f. Private duty nursing; or
    g. Consumer Directed Personal Assistance Services, and
8) Must enroll in VillageCareMAX Medicare Total Advantage Plan Medicare Advantage Product.

The coverage explained in this chapter becomes effective on the effective date of your enrollment in VillageCareMAX Medicare Total Advantage Plan MAP Program. Enrollment in the MAP Program is voluntary.

New York Independent Assessor - Initial Assessment Process

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date. 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 Medicare Total Advantage Plan 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 Medicare Total Advantage Plan about whether the plan of care meets your needs.

Once NYIA has completed the initial assessment steps, determined that you are eligible for Medicaid Managed Long Term Care, and you have agreed to the plan of care developed for you, you can then choose which Managed Long Term Care plan in which to enroll. Because you also are enrolled in Medicare for this same plan, you have chosen to combine your benefits and enroll in VillageCareMAX Medicare Total Advantage Plan.

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.

Enrollment Steps for Medicare
Since VillageCareMAX Medicare Total Advantage Plan also covers Medicare services, a licensed Medicare Marketing Representative contacts you and provides a VillageCareMAX Medicare Total Advantage introduction via telephone or in-person. Then the Intake Coordinator contacts you to schedule an appointment with the Nurse Assessor, who reviews the Plan-of-Care and assists with completing the Medicaid enrollment agreement to enroll you in the Medicaid Advantage Plus part of VillageCareMAX Medicare Total Advantage Plan. The 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 Plan.

Once all of the above is complete, your enrollment request will be submitted to Medicaid and Medicare for approval. They are responsible for processing all enrollments.

- If Medicaid receives the completed enrollment package by the 20th day of the month, the enrollment will take effect on the first day of the next month. (For example: If your completed enrollment package is submitted by January 20, your enrollment would take place on February 1.)
- If Medicaid receives the enrollment package after the 20th day of the month, the enrollment must take effect no later than the first day of the second month. (For example: If your completed enrollment package is submitted on January 22, your enrollment would take place on March 1.)

If you change your mind and choose not to enroll in the program, you can withdraw your application at any time before your enrollment becomes effective. VillageCareMAX will notify Medicaid and Medicare as appropriate, and will mail you a confirmation of cancellation letter. If your enrollment request was already sent to Medicare and Medicaid, the Plan must receive approval or notification from both Medicare and Medicaid to cancel your enrollment. You can cancel your enrollment in the Medicaid Advantage Plus (MAP) part of the plan before noon of the 20th day before your enrollment becomes effective. If your enrollment request was already sent to Medicare, your last day to cancel your enrollment in the Medicare Advantage part of the plan will be included in the enrollment verification letter mailed to you from VillageCareMAX. As much as possible, the Plan will work with you to ensure that the effective date of cancellation is the same for from both Medicare and Medicaid.

During the enrollment process, if it is found that you are not eligible for enrollment into VillageCareMAX, you will be informed in writing of the decision. Anytime your enrollment is going to be denied, Medicaid must approve this decision. VillageCareMAX will deny your enrollment under the following conditions:

- You do not meet the eligibility criteria listed above;
  You do not need community-based long-term care services of the Plan for a continuous period of more than 120 days;
- You are enrolled in one of the following: another managed care plan capitated by Medicaid, a Traumatic Brain Injury or Nursing Home Transition and Diversion Waiver program, a hospice, a State Office for People with Developmental Disabilities (OPWDD) program and you do not want to disenroll from any of these services;
- You are a resident of psychiatric facility, alcohol/substance abuse long term residential treatment or assisted living programs;
- You are expected to have Medicaid for less than 6 months, have Emergency Medicaid or are in Medicaid family planning expansion program;
- You are in the Foster Family Care Demonstration;
- You are a resident of an Assisted Living Program (ALP)

Plan Member (ID) Card
You will receive your VillageCareMAX Medicare Total Advantage Plan identification (ID) card within 10 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at, 1-800-469-6292 (TTY/TDD: 711)

SERVICES COVERED BY THE VillageCareMAX Medicare Total Advantage Plan MAP PROGRAM

Deductibles and Copayments on Medicare Covered Services
Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the VillageCareMAX Medicare Total Advantage Plan Evidence of Coverage. Sections 2 and 3 of VillageCareMAX Plan. The Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of VillageCareMAX Medicare Total Advantage Plan Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined VillageCareMAX plan, and you have Medicaid, VillageCareMAX will pay these amounts. You do not have to pay these deductibles and co- payments except for those that apply to some pharmacy items.

If there is a monthly premium for benefits (see Section 8 of the VillageCareMAX Medicare Total Advantage Plan Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services
As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services.

Upon enrollment, you will be assigned a Care Manager who is a Registered Nurse or Social Worker. The Care Manager will help to coordinate your care and will follow-up with you on a regular basis to check on your health care status. He/she will work with your physician, and other health care providers, to ensure that you are receiving all needed and ordered services. The Care Manager will also work with you to ensure that the care planning process is centered on your needs and preferences.

Your plan of care will be developed with a care team led by the Care Manager with your participation. The care team also includes your doctor, your caregiver(s), and other health care providers who will work together to develop a plan of care that meets your needs. The plan of care is a written description of your needs, services, and goals. 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.

You can call our Member Services number at 1-800-469-6292 (TTY: 711) for after hours care. 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. Note: if you have an emergency, please call 911.

Additional Covered Services
Because you have Medicaid and qualify for the MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in VillageCareMAX Medicare Total Advantage Plan network. If you cannot find a provider in our plan, 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

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.

Service	Coverage Rules
Adult Day Health Care Provides care and services in a residential health care facility or approved extension site. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as 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.	You must get Adult Day Health Care from the VillageCareMAX Provider Network, and 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.
Audiology/Hearing Aids 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.	You must get audiology/hearing aids from the VillageCareMAX Provider Network. Prior authorization may be required for certain services.
Consumer Directed Personal Assistance (CDPAS) 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.	You must coordinate your consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX. Prior authorization is required from VillageCareMAX.
Dental Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.	You must get dental services from the VillageCareMAX dental Provider Network. Prior authorization is required for certain services.

Service	Coverage Rules
Durable Medical Equipment (DME) 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.	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.
Home-Delivered Meals and/or Meals in a Group Setting such as a day care 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.	You must get home delivered or congregate meals from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.
Home Health Care Services Not Covered by Medicare (including nursing, home health aide, occupational, physical and speech therapies) Medicaid-covered home health services include the provision of skilled services not covered by Medicare. VillageCareMAX Medicare Total Advantage Plan 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.	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.
Medical Social Services 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.	You must get Medical Social Services from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.

Service	Coverage Rules
Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies 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.	These items may also 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.
Non-emergency Transportation 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.	You must get non-emergency transportation from the VillageCareMAX Provider Network, and call two days in advance to schedule, if possible.
Nursing Home Care not covered by Medicare (*provided you are eligible for institutional Medicaid*) Medicaid-covered care provided in a Skilled Nursing Facility.	You must get Medicaid covered nursing home care from the VillageCareMAX Provider Network provider, and get authorization from the Plan. 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.
Nutrition Services/Counseling 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.	You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network, and get authorization from the Plan.

Service	Coverage Rules
Outpatient Rehabilitation ***Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home*** Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. 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. 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.	VillageCareMAX covers medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. Prior authorization is required from VillageCareMAX. 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.
Optometry/Eyeglasses 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.	You must get optometry services and eyeglasses from the VillageCareMAX Provider Network. Prior authorization may be required for certain services.
Personal Care (such as assistance with bathing, eating, dressing, toileting and walking) Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks.	You must get personal care from the VillageCareMAX Provider Network, and get authorization from the Plan. Your doctor will need to provide signed written orders. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Personal Emergency Response Systems (PERS) PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	You must get PERS from the VillageCareMAX Provider Network, and get authorization from the Plan.

Service	Coverage Rules
Podiatry 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.	You can get podiatry services from the VillageCareMAX Provider Network. Prior authorization is not required.
Private Duty Nursing 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).	You must get private duty nursing services from the VillageCareMAX Provider Network and requires a doctor's order. Prior authorization is required from VillageCareMAX.
Prosthetics, Orthotics and Orthopedic Footwear Prosthetic appliances and devices are appliances and devices that replace any missing part of the body. 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. 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.	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.

Service	Coverage Rules
Respiratory Therapy 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.	You must get respiratory therapy from the VillageCareMAX Provider Network, and 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.
Social and Environmental Supports (such as chore services, home modifications or respite) 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.	You must get social and Environmental supports from the VillageCareMAX Provider Network, and get authorization from the Plan.
Social Day Care 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.	You must get Social Day Care from the VillageCareMAX Provider Network, and get authorization from the Plan.
Telehealth 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.	Telehealth can be received to support covered services only. You must get authorization from the Plan, as required.
Veteran's Home Services If you are a veteran, spouse of a veteran, or Gold Star parent in need of long-term nursing home services, you may access Veteran's Home Services.	If VillageCareMAX does not have an accessible in-network veteran's home, the plan will authorize out-of-network services until member is transferred to another plan with an in-network veteran's

	home. You must get authorization from the Plan.

The following services are also included in the MAP Plan effective January 1, 2023:

- **Continuing Day Treatment (CDT)**
- **Partial Hospitalization (PH)**
- **Assertive Community Treatment (ACT)**
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)**
- **Personalized Recovery Oriented Services (PROS)**
- **Community Oriented Recovery and Empowerment (CORE) Services**
  - **Psychosocial Rehabilitation (PSR)**
  - **Community Psychiatric Supports and Treatment (CPST)**
  - **Empowerment Services – Peer Supports**
  - **Family Support and Training (FST)**
- **Comprehensive Psychiatric Emergency Program (CPEP)**
- **Mobile Crisis and Telephonic Crisis Services**
- **Crisis Residential Programs**
- **Opioid Treatment Centers (OTP)**
- **OASAS Certified Title 14 Part 820 Residential services**
- **State Operated Addiction Treatment Center's (ATC)**
- **Inpatient addiction rehabilitation**
- **Inpatient Medically Supervised Detox**

Limitations
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.

Getting Care Outside the Service Area
You must inform your care manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care manger should be contacted to assist you in arranging services.

Emergency Service
Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify VillageCareMAX Medicare Total

Advantage Plan within 24 hours of the emergency. You may be in need of long term care services that can only be provided through VillageCareMAX Medicare Total Advantage Plan.

If you are hospitalized, a family member or other caregiver should contact VillageCareMAX Medicare Total Advantage Plan within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact VillageCareMAX so that we may work with them to plan your care upon discharge from the hospital.

Transitional Care Procedures
New enrollees in VillageCareMAX Medicare Total Advantage Plan may continue an ongoing course of treatment for a transitional period of up to 90 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to VillageCareMAX Medicare Total Advantage Plan quality assurance and other policies, and provides medical information about the care to the plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

Money Follows the Person (MFP)/Open Doors
This section will explain the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP/Open Doors 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 with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that VillageCareMAX Medicare Total Advantage Plan does not cover but may be covered by regular Medicaid. 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 Plan or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy
Most prescription drugs are covered by VillageCareMAX Medicare Total Advantage Plan Medicare Part D as described in section 6 of the VillageCareMAX Medicare Total Advantage Plan Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by VillageCareMAX Medicare Total Advantage Plan Medicare Part D. Medicaid may also cover drugs that we deny.

Certain Mental Health Services, including:
- Health Home (HH) and Health Home Plus (HH+) Care Management services
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment
- OASAS Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)
- OMH Residential Treatment Facility (RTF)
- Crisis Intervention Services for Youth ages 18-20

For MAP enrollees up to the age of 21:
- Children and Family Treatment and Support Services (CFTSS)
- Children's Home and Community Based Services (HCBS)

Certain Intellectual Disability and Developmental Disabilities Services, including:
- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services
- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, for members meeting criteria

Family Planning
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).

SERVICES NOT COVERED BY VillageCareMAX Medicare Total Advantage Plan **OR MEDICAID**
You must pay for services that are not covered by VillageCareMAX or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by VillageCareMAX Medicare Total Advantage Plan or

Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless VillageCareMAX sends you to that provider)

If you have any questions, call Member Services at 1-800-469-6292 (TTY: 711).

SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

You have Medicare and also 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 241 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
Attention: Utilization Management
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 Utilization Management Department or contracted vendor before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- **Adult Day Health Care**
- **Audiology/Hearing Aids***
- **Consumer Directed Personal Assistance (CDPAS)**
- **Dental***
- **Durable Medical Equipment (DME)***
- **Home Delivered Meals and/or meals in a group setting such as a day care**
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies
- **Medical Social Services**
- **Medical Supplies**
- **Non-Emergency Transportation**
- **Nursing Home Care not covered by Medicare** ***(provided you are eligible for institutional Medicaid)***
- **Nutrition**
- **Optometry/Eyeglasses***
- **Outpatient Rehabilitation –** ***Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home***
- **Personal Care**
- **Personal Emergency Response System (PERS)**
- **Private Duty Nursing**
- **Prosthetics, Orthotics and Orthopedic Footwear**
- **Respiratory Therapy**
- **Social and Environmental Supports**
- **Social Day Care**
- **Telehealth***
- **Veteran's Home Services**

An asterisk (*) means that prior authorization is required for certain services. Call the plan for more information.

Before you can get these services, you or your provider must submit the request to VillageCareMAX for prior authorization. This can be done by calling VillageCareMAX Member Services or sending your request in writing. The Utilization Management team will review your request, which includes working with providers to get all necessary medical documentation. A decision will be made as early as your condition requires, but no later than the required timeframes. See the benefit chart on pages 5-9 for more information on description of services and coverage rules.

Concurrent Review

You can also ask VillageCareMAX Utilization Management Department or contracted vendor to 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 plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or ***fast track*** process. You or your doctor can ask for a *fast track* review if it is believed that a delay will cause serious harm to your health. If your request for a *fast track* review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Timeframes for prior authorization requests

- **Standard review**: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- **Standard review**: We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- **Fast track review**: We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a *fast track* review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-469-6292 (TTY: 711) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If 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. See ***How do I File an Appeal of an Action?*** which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When VillageCareMAX denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions. An action is subject to appeal. (See *How do I File an Appeal of an Action?* below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; ***and***
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you must file an appeal before asking for a Fair Hearing; ***and***
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 day of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-800-469-6292 (TTY: 711), or writing to 112 Charles St, New York, NY 10014. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see "***How do I File an Appeal of an Action?"*** above.

Although you may request a continuation of services, if the plan appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will It Take the Plan to Decide My Appeal of an Action?

Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request a "*fast track*" appeal. (See "**Fast Track Appeal Process"** section below.)

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a *fast tracked* review of your appeal. of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more

than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for a *fast track* appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for a *fast track* appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: **You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.** If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under ***"How Long Will It Take the Plan to Decide My Appeal of an Action?"*** *above*, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance (OTDA):

- Online Request Form: Request Hearing | Fair Hearings | OTDA (ny.gov)
- Mail a Printable Request Form:
  NYS Office of Temporary and Disability Assistance Office
  of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:
  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155
- Request in Person:
  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

  Albany
  40 North Pearl Street, 15th Floor
  Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:
http://otda.ny.gov/hearings/request/

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast track external appeal. The external appeal reviewer will decide a fast track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

COMPLAINTS AND COMPLAINT APPEALS

VillageCareMAX will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by VillageCareMAX staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: 1-800-469-6292 (TTY: 711) or write to: 112 Charles St, New York, NY 10014. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you, didn't show up, or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial compliant decision.

For standard complaint appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the *fast track* complaint appeal process. For *fast track* complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and *fast track* complaint appeals, we will provide you with written notice of our decision of your complaint appeal. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like VillageCareMAX. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

- Phone: 1-844-614-8800 (TTY Relay Service: 711)
- Web: www.icannys.org | Email: ican@cssny.org

DISENROLLMENT FROM VillageCareMAX MLTC PLAN

You will not be disenrolled from the MLTC Plan based on any of the following reasons:

- high utilization of covered medical services
- an existing condition or a change in your health
- diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs unless the behavior results in your becoming ineligible for MLTC.

Voluntary Disenrollment

You can ask to leave the VillageCareMAX at any time for any reason.

To request disenrollment, call 1-800-469-6292 (TTY: 711) or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers

You can try our plan for 90 days. You may leave VillageCareMAX and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in VillageCareMAX for nine more months, unless you have good reason (good cause.)

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving VillageCareMAX is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause.

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. VillageCareMAX will provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in VillageCareMAX.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by VillageCareMAX. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You Will Have to Leave VillageCareMAX if you are:

- No longer are Medicaid eligible.
- Permanently move out of VillageCareMAX service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave VillageCareMAX if you:

- or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services
- fail to pay or make arrangements to pay the amount money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, VillageCareMAX will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need CBLTSS you will be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan.

CULTURAL AND LINGUISTIC COMPETENCY

VillageCareMAX honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

MEMBER RIGHTS AND RESPONSIBILITIES

VillageCareMAX will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member Rights

- 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 or 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 told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services.
- You have the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- Receiving covered services through VillageCareMAX.
- Using VillageCareMAX network providers for covered services to the extent network providers are available.

- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs.
- Sharing complete and accurate health information with your health care providers.
- Informing VillageCareMAX staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Following the plan of care recommended by the VillageCareMAX staff (with your input).
- Cooperating with and being respectful with the VillageCareMAX staff and not discriminating against VillageCareMAX staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status.
- Notifying VillageCareMAX within two business days of receiving non-covered or non-pre-approved services.
- Notifying your VillageCareMAX health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing VillageCareMAX before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Meeting your financial obligations.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your care manager.

Information Available on Request

- Information regarding the structure and operation of VillageCareMAX.
- Specific clinical review criteria relating to a particular health condition and other information that VillageCareMAX considers when authorizing services.
- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Provider credentialing policies.
- A recent copy of the VillageCareMAX certified financial statement; policies and procedures used by VillageCareMAX to determine eligibility of a provider.

VillageCareMAX Medicare Total Advantage Plan Member Services

Method	Member Services – Contact Information
CALL	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.
TTY	[[711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-212-337-5711
WRITE	VillageCareMAX Attention: Utilization Management 112 Charles Street, New York, NY 10014
WEBSITE	www.villagecaremax.org

New York State Health Insurance Information Counseling and Assistance Program/HIICAP

Health Insurance Information Counseling and Assistance Program/HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Health Insurance Information, Counseling and Assistance Program (HIICAP)– Contact Information
CALL	1-800-701-0501 Calls to this number are free. Available Monday through Friday, 9:00 am to 4:00 pm
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available Monday through Friday, 9:00 am to 4:00 pm
WRITE	Health Insurance Information, Counseling and Assistance Program (HIICAP) 2 Lafayette Street, 9th Floor New York, NY 10007-1392
WEBSITE	https://aging.ny.gov/health-insurance-information-counseling-and-assistance

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*