VILLAGECAREMAX

Are you getting the most out of your Medicare plan?



MEDICARE TOTAL ADVANTAGE PLAN (HMO D-SNP)

Evidence of Coverage

January 1 - December 31, 2027

www.villagecaremax.org

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug coverage as a Member of VillageCareMAX Medicare Total Advantage Plan HMO D-SNP

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

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

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

For questions about this document, call Member Services at 1-855-296-8800 (TTY users call 711). Hours are 7 days a week, 8 am to 8 pm. This call is free.

This plan, VillageCareMAX Medicare Total Advantage Plan, is offered by VillageCareMAX (When this Evidence of Coverage says "we," "us," or "our," it means VillageCareMAX. When it says "plan" or "our plan," it means VillageCareMAX Medicare Total Advantage Plan.)

This document is available for free in Spanish, Chinese, Arabic, Korean, Russian, Italian, French, Creole, Yiddish, Polish, Tagalog, Bengali, Albanian, Greek, and Urdu. This information is also available in large print, braille, or audio.

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

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

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

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of VillageCareMAX Medicare Total Advantage Plan

Section 1.1 You're enrolled in VillageCareMAX Medicare Total Advantage Plan, which is a Medicare Special Needs Plan

You're 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 aren't covered by Medicare.

You've chosen to get your Medicare and Medicaid health care and your drug coverage through our plan, VillageCareMAX Medicare Total Advantage Plan. Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

VillageCareMAX Medicare Total Advantage Plan is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. VillageCareMAX Medicare Total Advantage Plan is designed for people who have Medicare and are entitled to help from Medicaid.

Because you get help from Medicaid with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Medicaid also provides other benefits by covering health care services that aren't usually covered under Medicare. You'll also get Extra Help from Medicare to pay for the costs of your Medicare drugs. VillageCareMAX Medicare Total Advantage Plan will help you manage all these benefits, so you get the health services and payment help that you're 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. Our plan also has a contract with the New York Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare and Medicaid coverage, including drug coverage.

Section 1.2 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 get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in VillageCareMAX Medicare Total Advantage Plan between January 1, 2027, and December 31, 2027.

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

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.
- 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 get 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 Medicare and Full Medicaid Benefits.

1. Must be 18 years of age or older;
2. Must be eligible for nursing home level of care (as of the time of enrollment) using the Uniform Assessment System (UAS) or other tool designated by the New York State Department of Health;
3. Must be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, based upon criteria provided by the New York State Department of Health; and
4. For new enrollees, starting September 1, 2025, the Managed Long-Term Care (MLTC) Program eligibility criteria to join a Medicaid Advantage Plus (MAP) plan requires an individual to be assessed as in need of care management and Community Based Long Term Care Services and Support (CBLTSS) for more than 120 continuous 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 the following Minimum Need from the effective date of enrollment:
    - At least limited assistance with physical maneuvering with more than two activities of daily living (ADLs); or
    - Individuals with a Dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL.

    If you enrolled in any MLTC Plan prior to September 1, 2025, you will not be subject to the new Minimum Needs Requirements at reassessment as long as you remain continuously enrolled in any MLTC Plan. If you leave the MLTC Program and want to rejoin, you will need to meet the eligibility criteria that is in place for the MLTC enrollment at the time you rejoin.

Note: If you lose your New York Medicaid eligibility but can reasonably be expected to regain eligibility within 3 -month(s), then you're still eligible for membership. Chapter 4, Section 2.1 tells you about coverage and cost sharing during this period.

Section 2.2 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's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+)**: Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). These individuals are also eligible for full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE)**: Eligible for full Medicaid benefits, and payment of your Medicare Part A premiums (in some cases) and Medicare Part B premiums.

Section 2.3 Plan service area for VillageCareMAX Medicare Total Advantage Plan

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

Our service area includes these counties in New York: Bronx, Kings, New York, Queens, Nassau, Richmond, Westchester, and Putnam.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-855-296-8800 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

Section 2.4 U.S. citizen or national, or eligible noncitizen

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

SECTION 3 What to expect when you first join our plan

Section 3.1 Health risk assessment

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. The HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We'll reach out to you to complete the HRA. This can be done over the phone, over a video call, or in person. We'll send you more information about this HRA. We'll then contact you annually for any updates to determine if your needs have changed.

Section 3.2 Care team and care plan

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, specialists you see, or other health professionals that you choose.

You work with a care team to make a care plan based on your preferences. A care plan tells you and your doctors and other health providers what services you need and how to get them. It includes your medical, behavioral health, and other services.

Your care plan includes:

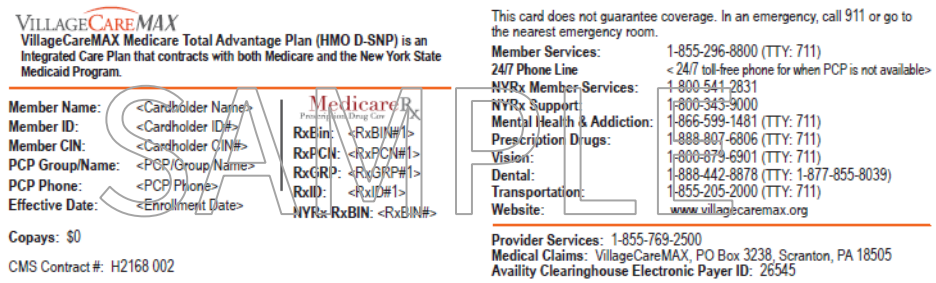
- your health care goals as prioritized by you, and
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask about the services you need. They also tell you about services you may want to think about getting. Your care team works with you to update your care plan at least every year or as needed if you have any changes in your health status.

SECTION 4 Important membership materials

Section 4.1 Our plan membership card

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



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your 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 our plan membership card is damaged, lost, or stolen, call Member Services at 1-855-296-8800 (TTY users call 711) right away and we'll send you a new card.

Section 4.2 Provider Directory

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

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

The most recent list of providers and suppliers on our website at www.villagecaremax.org.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services 1-855-296-8800 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

Section 4.3 Pharmacy Directory

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

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services 1-855-296-8800 (TTY users call 711). You can also find this information on our website at www.villagecaremax.org.

Section 4.4 Drug List (formulary)

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

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit www.villagecaremax.org or call Member Services at 1-855-296-8800 (TTY users call 711).

SECTION 5 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 5.1 for details.	**$0**

	Your Costs in 2027
Deductible	**$0**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1.2 for details.)	**$9,850** **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.**
Primary care office visits	**$0 per visit**
Specialist office visits	**$0 per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**$0**

	Your Costs in 2027
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible** ***$0*** ***Copayment* during the Initial Coverage Stage:** **Drug Tier 1: $0** **Drug Tier 2: $0** **Drug Tier 3: $0** **Drug Tier 4: $0** **Drug Tier 5: $0** **Drug Tier 6: $0** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

Your costs may include the following:

- Plan Premium (Section 5.1)
- Monthly Medicare Part B Premium (Section 5.2)
- Part D Late Enrollment Penalty (Section 5.3)
- Income Related Monthly Adjusted Amount (Section 5.4)

Section 5.1 Plan premium

You don’t pay a separate monthly plan premium for VillageCareMAX Medicare Total Advantage Plan, your plan premium is paid on your behalf by Extra Help.

Section 5.2 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 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 Part B premium.

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

Section 5.3 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply 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 was a period of 63 days or more in a row when you didn't have Part D or other creditable 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 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'll generally have to pay this penalty for as long as you have Part D coverage.

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

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or a newsletter from that plan. Keep this information, because you may need it if you join a Medicare drug plan later.

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

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

- 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 drug coverage, if the break in coverage was 63 days or more.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.7862. This rounds to $5.79. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

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

- **The penalty may change each year,** because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

Section 5.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes to your income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is

above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit Medicare.gov/health-drug-plans/part-d/basics/costs.

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

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

SECTION 7 Keep your plan membership record up to date

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

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

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

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

If any of this information changes, let us know by calling Member Services 1-855-296-8800 (TTY users call 711).

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

SECTION 8 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-855-296-8800 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 VillageCareMAX Medicare Total Advantage Plan contacts

For help with claims, billing, or member card questions, call or write to VillageCareMAX Medicare Total Advantage Plan Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	1-855-296-8800 Calls to this number are free. 7 days a week, 8 am to 8 pm. Member Services 1-855-296-8800 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.
Fax	1-212-337-5711
Write	VillageCareMAX Attn: Member Services 120 Broadway, Suite 2480 New York, NY 10271
Website	www.villagecaremax.org

How to ask 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 pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	1-855-296-8800 Calls to this number are free. 7 days a week, 8 am to 8 pm.

TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.
Fax	1-212-337-5711
Write	Appeals: VillageCareMAX Attn: Grievance and Appeals Department 120 Broadway, Suite 2480 New York, NY 10271 Coverage Decisions: VillageCareMAX 120 Broadway, Suite 2480 New York, NY 10271
Website	www.villagecaremax.org

Coverage Decisions for Part D drugs – Contact Information	
Call	1-888-807-6806 Calls to this number are free. 7 days a week, 8 am to 8 pm.
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.
Fax	1-858-790-7100
Write	MedImpact Healthcare Systems Attn: Prior Authorization Department 10181 Scripps Gateway Ct. San Diego, CA 92131
Website	https://mp.medimpact.com/partdcoveragedetermination

Appeals and Complaints for Part D prescription drugs – Contact Information	
Call	1-888 807-6806 Calls to these numbers are free. 7 days a week, 8 am to 8 pm
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm
Write	MedImpact HealthCare Systems, Inc. Attn: Appeals and Grievances Department 10181 Scripps Gateway Ct. San Diego, CA 92131

Medicare Website	To submit a complaint about VillageCareMAX Medicare Health Advantage Plan directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	1-855-296-8800 Calls to this number are free. 7 days a week, 8 am to 8 pm.
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.
Write	VillageCareMAX Attn: Grievance and Appeals Department 120 Broadway, Suite 2480 New York, NY 10271
Medicare website	To submit a complaint about VillageCareMAX Medicare Total Advantage Plan directly to Medicare, go to Medicare.gov/my/medicare-complaint.

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

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

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

Payment Requests for Medical Care – Contact Information	
Call	1-855-296-8800 Calls to this number are free. 7 days a week, 8 am to 8 pm.
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.

Write	VillageCareMAX 120 Broadway, Suite 2480 New York, NY 10271
Website	www.villagecaremax.org

Payment Requests for Part D Drugs – Contact Information	
Call	1-888-807-6806 Calls to this number are free. 7 days a week, 8 am to 8 pm.
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.
Fax	1-858-549-1569
Write	MedImpact Healthcare Systems P.O. Box 509108 San Diego, CA 92150-9108
Email	Claims @Medimpact.com

SECTION 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.

Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like • screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about VillageCareMAX Medicare Total Advantage Plan. **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

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

Health Insurance information, Counseling, and Assistance Programs (HIICAP) – Contact Information	
Call	1-800-701-0501
Website	https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health, New York's Quality Improvement Organization) – Contact Information	
Call	866-815-5440 Monday- Friday: 9 am to 5 pm Saturday- Sunday and Holidays: 10 am to 4 pm
TTY	711
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454 communiations@commence.ai
Website	https://devqa.livantaqio.com/contact-information.html

SECTION 5 Social Security

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

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

Social Security– Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. 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 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

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 contracts with the state to provide dually-eligible individuals with long-term care services and supports.

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

- **Qualified Medicare Beneficiary Plus (QMB+)**: Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). These individuals are also eligible for full Medicaid benefits.

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

If you have questions about the help you get from Medicaid, contact New York State Medicaid.

New York State Medicaid – Contact Information	
Call	800-541-2831 Monday- Friday 8 am- 8 pm Saturday 9 am to 1 pm
TTY	711
Write	You can write to your Local Department of Social Services. Find the address for your LDSS https://www.health.ny.gov/health_care/medicaid/ldss/
Website	https://www.health.ny.gov/health_care/medicaid/

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

Independent Consumer Advocacy Agency Network (ICAN) – Contact Information	
Call	1-844-614-8800 8 am to 6 pm
TTY	711
Write	Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017 ican@cssny.org
Website	https://icannys.org

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

New York State Long Term Care Ombudsman – Contact Information	
Call	1-855-582-6769

	Mon.-Fri. 9:00 AM – 5:00 PM
Write	2 Empire State Plaza, 5th Floor Albany, NY 12223 EMAIL: ombudsman@aging.ny.gov
Website	www.aging.ny.gov/long-term-care-ombudsman-program

SECTION 7 Programs to help people pay for prescription drugs

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

Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't 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 call 1-877-486-2048,
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at 800-541-2831.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with 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, the New York State document that confirms Medicaid status, or an award letter from the Social Security Administration.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a

debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 1-855-296-8800 (TTY users call 711) if you have questions.

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

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

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

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

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

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call New York State AIDS Drug Assistance Program.

State Pharmaceutical Assistance Programs

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

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

Elderly Pharmaceutical Insurance Coverage (EPIC) New York's State Pharmaceutical Assistance Program) – Contact Information	
Call	1-800-332-3742
TTY	1-800-290-9138

	This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	EPIC P.O. Box 15018 Albany, NY 12212-5018 nysdohepic@primetherapeutics.com
Website	https://www.health.ny.gov/health_care/epic/application_contact.htm

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

CHAPTER 3:
Using our plan for your medical and other covered services

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

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

Section 1.1 Network providers and covered services

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

Section 1.2 Basic rules for your medical care and other services to be covered by our 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 more details).

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

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
    - In most situations, our plan must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (see Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means that you have to pay the provider in full for services you get. Here are 3 exceptions:
    - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
    - If you need medical care that Medicare 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. Get authorization from our plan before seeking care. In this situation, we'll cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services

inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

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

- Explain the role of a PCP in your plan.

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

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

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

- What is the role of the PCP in making decisions about or getting a 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 to choose a 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 in Chapter 2 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.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. If you change your PCP, this can result in being limited to certain specialists or hospitals to which that PCP refers.

To change your PCP, call Member Services to request a new PCP (contact information is in Chapter 2 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.

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 Medical care and other services you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing

conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-855-296-8800 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're 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. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions
- You do not need a referral from your PCP to see a specialist in our network. You can get these services on your own or your PCP can provide you with assistance if you need help selecting a specialist. If you need additional services, your PCP or specialist will need to get "prior authorization" (approval in advance) from VillageCareMAX for certain services including some diagnostic tests, home health services, and durable medical equipment. Please refer to the Benefits Chart in Chapter 4 for a complete listing of all services that require prior authorization.
- Prior authorization may be required for certain services and drugs. This means that you will need approval in advance before you can get these benefits. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary. You or your provider can request prior authorization from the plan by phone or in writing. The plan will review your request and make a decision if it is medically necessary to cover the service or drug. You can see any provider in the plan's network. A referral is not required from your PCP.
- If you change your PCP, this can result in being limited to certain specialists or hospitals to which that PCP refers.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. You need an authorization from the plan before seeking care.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

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.

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

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call us at 1-855-296-8800 (TTY 711) from 7 days a week, 8 am to 8 pm so we can help.

Covered services in a medical emergency

Medicare does not provide emergency/urgent coverage outside the United States and its territories.

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

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

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

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

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

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

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 emergency medical 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 Get care during a disaster

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

Visit www.villagecaremax.org for information on how to get needed care during a disaster.

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

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

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

Section 4.1 If services aren't covered by our plan

Before paying for the cost of the service, you should check with our plan if the service is covered by Medicaid.

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

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Once a benefit limit has been reached, your out of pocket costs will not count toward your out-of-pocket maximum. 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 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it 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'll pay nothing for the covered services you get in the clinical research study.

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

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

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

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

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

Medicare Inpatient Hospital 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 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of VillageCareMAX Medicare Total**

Advantage Plan, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. You won't get ownership, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at 1-855-296-8800 (TTY users call 711) for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage 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, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you with services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing

for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's covered)

SECTION 1 Understanding covered services

The Medical Benefits Chart lists your covered services as a member of VillageCareMAX Medicare Total Advantage Plan. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 You pay nothing for your covered services

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

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

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is $9,850.**

The amounts you pay for copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $9,850, you won't have to pay any out-of-pocket costs for the rest of the year for covered 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 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services VillageCareMAX Medicare Total Advantage Plan covers (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

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

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including copays and coinsurance for doctor visits. Medicaid also covers services Medicare doesn't cover, like long-term care, certain over-the-counter drugs, home and community-based services, or other Medicaid-only services.

- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- In addition to Medicare coverage under VillageCareMAX Total Advantage Plan, you are also covered by Medicaid. The below Benefits Chart in this chapter shows a list of the Medicare-covered services and items. Medicaid covers your cost sharing for Medicare services.
- If you're within our plan's 3-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we won't 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. For more information, you may call Member Services at 1-855-296-8800 (TTY users call 711).

You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed 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, Immunodeficiency and Immunosuppressive disorders; Overweight, obesity, and metabolic syndrome; Post-organ transplantation; Conditions associated with cognitive impairment; Conditions with functional challenges; Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell; Conditions that require continued therapy services in order for individuals to maintain or retain functioning.

  - 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.

- For more detail, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

 This apple shows the preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	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 under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	$0 for each Medicare-covered visit.

Covered Service	What you pay
Acupuncture for chronic low back pain* (continued) • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
Acupuncture (routine benefit)* Benefit includes: 40 visits every year, 5 visits maximum per month $80 maximum benefit limit per visit	$0 copay for each routine visit.
Ambulance services* Prior authorization is required for non-emergency ambulance transportation. Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$0 for each Medicare-covered ground ambulance service. $0 for each Medicare-covered air ambulance service. Cost sharing applies to each one-way trip.
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.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Covered Service	What you pay
Annual wellness visit (continued) This is covered once every calendar year (January - December) after your first (initial) annual wellness visit. **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.	
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, 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 aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain)	$0 for each Medicare-covered cardiac rehabilitation services visit. $0 for each Medicare-covered intensive cardiac rehabilitation services visit.

Covered Service	What you pay
Cardiac rehabilitation services* (continued) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
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 screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Covered Service	What you pay
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct a vertebral subluxation	$0 for each Medicare-covered chiropractic visit.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 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.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Covered Service	What you pay
Colorectal cancer screening (continued) • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: In addition, we cover diagnostic, preventive and comprehensive services. For a complete list of covered services and limitations, please reference the New York State Policy and Procedure Codes Manual at https://www.emedny.org/ProviderManuals/Dental/.	$0 for Medicare-covered dental services. Service limits apply for diagnostic, preventive and comprehensive dental. Coverage subject to change per Medicaid coverage. $0 copay, no allowance limit for additional dental benefits, but some service limits apply.
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.

Covered Service	What you pay
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting. • Diabetes self-management training under certain conditions. • Members may obtain diabetic supplies with a healthcare provider's prescription at participating network retail or mail order pharmacies. Abbott is the preferred manufacturer for blood glucose, glucometers, and testing supplies. Abbott and Dexcom are the preferred manufacturers for continuous glucose monitors and related testing supplies. If another manufacturer's product is needed, it is managed through the formulary exception process.	$0 for Medicare-covered diabetic monitors and monitoring supplies. $0 for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. DME brands and manufacturers can be limited to those selected by our contracted DME suppliers. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.villagecaremax.org.	$0 for Medicare-covered durable medical equipment. Your cost sharing for Medicare oxygen equipment coverage is $0, every month. Your cost sharing won't change after you're enrolled for 36 months.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency care is covered worldwide. Please see **Worldwide emergency and urgently needed care services** row for details.	$0 for each Medicare-covered emergency room visit. ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the highest cost sharing you

Covered Service	What you pay
Emergency care (continued)	would pay at a network hospital.
Flex Benefit $645 per year allowance towards additional dental, vision, or hearing benefits ($53.75 per month, rolls over from month to month but expires at the end of the year).	$0 copay for the flex benefit.
Health and wellness education programs Benefits include: • Fitness benefit Members can access participating fitness centers with some locations offering heated pools and/or choose 1 home fitness kit per benefit year that could include, a pedometer, yoga mat, resistance tubing, Pilates ball, or foam roller at no cost. Coaching sessions, on-demand workout videos, virtual events, and online resources are also accessible to members.	$0 copay for the fitness benefit.
Hearing services* Prior authorization is required for certain services/items. Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. **Additional benefits include:** • up to $1,250 per year for hearing aids (maximum of $625 per ear). Flex benefit can be used for additional hearing services/items. Unused portion carries over from month to month but expires at the end of the year. • OTC hearing aids: unlimited hearing aids up to the OTC maximum plan coverage amount. Please see **Over-the-counter (OTC) items** row for details.	$0 for each Medicare-covered exam to diagnose and treat hearing and balance issues. $0 copay for prescription hearing aids – all types and OTC hearing aids. Dollar limit is based on OTC benefit.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:	There's no coinsurance, copayment, or deductible for members eligible for

Covered Service	What you pay
HIV screening (continued) • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	Medicare-covered preventive HIV screening.
Home health agency care* Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copay for Medicare-covered home health services.
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring	$0 for Medicare-covered home infusion therapy services.

Covered Service	What you pay
Home infusion therapy* (continued) • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our	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. We will coordinate services with your hospice provider and cover room and board should you be in a SNF or hospice residence.

Covered Service	What you pay
Hospice care (continued) plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by VillageCareMAX Medicare Total Advantage Plan but not covered by Medicare Part A or B:** VillageCareMAX Medicare Total Advantage Plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4). **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

Covered Service	What you pay
Immunizations (continued) • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. You are covered for 90 days per benefit period for Medicare-covered inpatient hospital stays. Covered services include but aren't 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 • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our	$0 for Medicare-covered inpatient hospital stays. 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 highest cost sharing you'd pay at a network hospital.

Covered Service	What you pay
Inpatient hospital care* (continued) 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 Plan* provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood 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 starting with the first pint. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. • Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay. You receive up to 190 days of Medicare-covered inpatient psychiatric hospital care in a lifetime. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	$0 for Medicare-covered inpatient mental health care stays. 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

Covered Service	What you pay
Inpatient services in a psychiatric hospital* (continued)	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.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay* If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, 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	**Physician services** See Physician/Practitioner Services, Including Doctor's Office Visits row. **Diagnostic and radiological services, surgical dressings, and splints** See Outpatient Diagnostic Tests and Therapeutic Services and Supplies row. **Prosthetics, orthotics, and outpatient medical/therapeutic supplies** See Prosthetic and Orthotic Devices and Related Supplies row. **Physical, speech, and occupational therapy services** See Outpatient Rehabilitation Services

Covered Service	What you pay
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed in the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs* **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and	$0 for Medicare Part B insulin drugs. Cost sharing for a one-month's supply is limited to $35. Service category and plan level deductibles don't apply. $0 for Medicare Part B chemotherapy and radiation drugs. $0 for other Medicare Part B drugs.

Covered Service	What you pay
Medicare Part B drugs* (continued) tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B	

Covered Service	What you pay
Medicare Part B drugs* (continued) • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Nurse Line Benefit includes access to a Nurse Line after hours, on holidays, and on weekends to provide health guidance for any non-emergency situation.	There is no coinsurance, copayment, or deductible for the Nurse Line.
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.

Covered Service	What you pay
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$0 for Medicare-covered opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to 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 • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests	**Outpatient X-rays** $0 for Medicare-covered services. **Therapeutic radiology services** $0 for Medicare-covered services (such as radiation treatment for cancer). **Medical supplies** $0 for Medicare-covered supplies. **Lab services** $0 for Medicare-covered services. **Blood services** $0 for Medicare-covered services. **Diagnostic tests and procedures** $0 for Medicare-covered services. **Diagnostic radiology**

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies* (continued)	**services** $0 for Medicare-covered services (such as MRIs and CT scans).
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	$0 for Medicare-covered outpatient hospital observation services.
Outpatient hospital services* We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • 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	$0 for Medicare-covered outpatient hospital services.

Covered Service	What you pay
Outpatient hospital services* (continued) • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed 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.	$0 for each Medicare-covered individual therapy visit with a psychiatrist. $0 for each Medicare-covered group therapy visit with a psychiatrist. $0 for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist). $0 for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).
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).	$0 for each Medicare-covered occupational therapy visit. $0 for each Medicare-covered physical and/or speech therapy visit.

Covered Service	What you pay
Outpatient substance use disorder services* Coverage includes treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.	$0 for each Medicare-covered individual therapy visit. $0 for each Medicare-covered group therapy visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$0 for Medicare-covered services at an ambulatory surgical center. $0 for Medicare-covered services at an outpatient hospital facility.
Over-the-counter (OTC) Card You are covered for up to $305 per month on your OTC card to buy approved items: • Non-prescription drugs and health-related items at participating locations or online for home delivery • OTC hearing aids • Items from participating retailers, such as additional fitness center memberships, approved fitness equipment, and approved digital cognitive training program for memory fitness Combined with the Special Supplemental Benefits for the Chronically Ill. Members eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI) may also use the OTC card for approved:	There is no cost for the OTC benefit. Food & produce (grocery items), gas-at-the-pump, utilities, rent/mortgage assistance, pest control, indoor air quality products, public transportation, transportation for non-medical needs are part of Special Supplemental Benefits for the Chronically Ill (SSBCI). In order to be eligible to receive SSBCI benefits, enrollees must be

Covered Service	What you pay
Over-the-counter (OTC) Card (continued) • Food and produce (grocery items) at participating locations or online for home delivery • Utilities • Rent or Mortgage Assistance • Gasoline at the pump • Indoor air quality products • Pest Control treatments or products • Bus/subway transit fare & rideshare Unused funds roll over month to month but expire at the end of the year.	determined to be chronically ill, have a chronic condition (e.g., diabetes, chronic heart failure, cardiovascular disorder, chronic and disabling mental health condition, stroke, or other eligible conditions), and meet coverage criteria. Members enrolled in the VillageCareMAX Medicare Total Advantage plan will qualify.
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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$0 per day for Medicare-covered partial hospitalization services. $0 for Medicare-covered intensive outpatient program services.
Physician/practitioner services, including doctor's office visits* Prior authorization required for additional telehealth.	$0 for each Medicare-covered primary care visit. $0 for each Medicare-covered specialist visit.

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits* (continued) Prior authorization not required for primary care and specialist office visits. Covered services include: • Medically necessary health care or surgery services given in places such as: o physician's office o certified ambulatory surgical center o hospital outpatient department o any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: outpatient services, doctor appointments, exams, education, screenings and more. o 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. o Telehealth services are offered in many ways, ask your doctor how to access telehealth services at their practice. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • 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	$0 for each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants). $0 for additional telehealth benefits, for inpatient hospital-acute, inpatient hospital psychiatric, skilled nursing facility (SNF), cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitation services, set for pad services, partial hospitalization program, home health services, primary care physician services, chiropractic services, occupational therapy services, physician specialist services, individual sessions for mental health specialty services, group sessions for mental health specialty services, podiatry services, other health care professional, individual sessions for psychiatric services, group sessions for psychiatric services, physical therapy and speech-language

Covered Service	What you pay

Physician/practitioner services, including doctor's office visits* (continued)
• 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
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ○ You're not a new patient **and**
  ○ The check-in isn't related to an office visit in the past 7 days **and**
  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another network provider prior to surgery
	pathology services, opioid treatment program services, outpatient hospital services, individual sessions for outpatient substance abuse, group sessions for outpatient substance abuse, kidney disease education services, glaucoma screening, diabetes self-management training, eye exams, hearing exams, intensive outpatient program services.

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	$0 for each Medicare-covered podiatry services visit.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • One time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	$0 for Medicare-covered prosthetic and orthotic devices. $0 for Medicare-covered medical supplies related to prosthetic and orthotic devices.

Covered Service	What you pay
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$0 for each Medicare-covered pulmonary rehabilitation services visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets 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 members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney diseases and dialysis 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 6 sessions of kidney disease education services per lifetime	$0 copay for Medicare-covered kidney disease education services. $0 for Medicare-covered dialysis services.

Covered Service	What you pay
Services to treat kidney disease (continued) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table**.**	
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, go to Chapter 12. 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 aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood 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.	Inpatient hospital stay is not required prior to admission. $0 for Medicare-covered SNF stays. 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

Covered Service	What you pay
Skilled nursing facility (SNF) care* (continued) 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 get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital •	the number of benefit periods.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay
Special supplemental benefits for the chronically ill Combined with OTC benefit. $305 maximum plan coverage amount every month for OTC items and Special Supplemental Benefits for the Chronically Ill (SSBCI). Members eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI) may also use the OTC card for approved: • Food and produce (grocery items) at participating locations or online for home delivery • Utilities • Rent or Mortgage Assistance • Gasoline at the pump • Indoor air quality products • Pest Control treatments or products • Bus/subway transit fare & rideshare Unused funds roll over month to month but expire at the end of the year. SSBCI benefits also include Non-Medical Transportation (24 one-way trips [12 round trips] per year). Food & produce (grocery items), gas-at-the-pump, utilities, rent/mortgage assistance, pest control, indoor air quality products, public transportation, transportation for non-medical needs are part of Special Supplemental Benefits for the Chronically Ill (SSBCI). In order to be eligible to receive SSBCI benefits, enrollees must be determined to be chronically ill, have a chronic condition (e.g., diabetes, chronic heart failure, cardiovascular disorder, chronic and disabling mental health condition, stroke, or other eligible conditions), and meet coverage criteria. Members enrolled in the VillageCareMAX Medicare Total Advantage plan will qualify.	There is no cost for SSBCI benefits.

Covered Service	What you pay
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques 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.	$0 for each Medicare-covered SET visit.
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgent care is covered worldwide. Please see **Worldwide emergency and urgently needed care services** row for details.	$0 for each Medicare-covered urgently needed services visit.

Covered Service	What you pay
Vision care* Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery	**Medicare-covered vision care** $0 for each eye exam to diagnose and treat diseases and conditions of the eye. $0 copay for an annual glaucoma screening. $0 for one pair of eyeglasses or contact lenses after cataract surgery.
Additional benefits include: • Routine eye exams: 1 exam every year $350 maximum plan coverage amount every year for all non-Medicare-covered eyewear. • Eyeglasses (lenses and frames): 1 every year, or • Eyeglasses lenses: 1 pair every year, or • Eyeglasses frames: 1 every year, or • Contact lenses: unlimited pairs every year up to plan maximum	$0 copay for each routine eye exam visit. $0 copay for non-Medicare covered eyeglasses. $0 copay for non-Medicare covered eyeglass lenses. $0 copay for non-Medicare covered eyeglass frames. $0 copay for non-Medicare covered contact lenses.

Covered Service	What you pay
Welcome to Medicare preventive visit Our 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 preventive services you need (including certain screenings and shots (or vaccines)), 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 want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.
Worldwide emergency and urgently needed care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. Benefit includes: • Emergency care • Urgently needed care • Emergency/urgently needed care transportation services	$0 copay for each emergency care visit outside of the United States and its territories. $0 copay for each urgently needed care visit outside of the United States and its territories. $0 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.

SECTION 3 Services covered outside of VillageCareMAX Medicare Total Advantage Plan

The following services aren't covered by VillageCareMAX Medicare Total Advantage Plan but are available through Medicaid:

- Assisted Living Program
- Certain Mental Health Services
    - Intensive Psychiatric Rehabilitation Treatment Programs

  - Day Treatment
  - Continuing Day Treatment
  - Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
  - Assertive Community Treatment (ACT)
  - Personalized Recovery Oriented Services (PROS)
- Community First Choice Options (CFCO)
- Community Based Long Term Care Services (CBLTCS)
  - Nursing services in the home
  - Therapies in the home
  - Home health aid services
  - Personal care services in the home
  - Adult day health care
  - Private duty nursing
  - Consumer Directed Personal Assistance Services
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for Tuberculosis (TB) Disease
- Family Planning Services
- HIV COBRA Case Management Program
- Home and Community Based Waiver Program Services
- Medicaid Pharmacy Benefits
- Methadone Maintenance Treatment Programs (MMTP)
- Office for People with Developmental Disabilities (OPWDD) services
- Personal Emergency Response System
- Rehabilitation Services Provided to Residents of OMH-Licensed Community Residences and Family-Based Treatment Programs
- Social Day Care
- Social and Environmental Supports
- Non-Emergency Medical Transportation

SECTION 4 Services that aren’t covered by our plan

This section tells you what services are excluded.

The chart below lists services and items that aren’t covered by our plan under any conditions or are covered by our 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 get 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.)

Services not covered by Medicare	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 doesn't 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 (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	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 chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Radial keratotomy, LASIK surgery, and other low vision aids	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Routine hearing exams or exams to fit hearing aids	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:
Using plan coverage for Part D drugs

How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, some information in this *Evidence of Coverage* about the costs for Part D prescription drugs not apply to you. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-855-296-8800 (TTY users call 711) and ask for the *LIS Rider*. (Phone numbers for Member Services are printed on the back cover of this document.)

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

Go to the Medical Benefits Chart in 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 under your Medicaid benefits. For more information about your Medicaid drug coverage, contact the New York State Medicaid Helpline at 800-541-2831 (TTY 1-800-662-1220).

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through your plan's mail-order service.)
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)

- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

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

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (www.villagecaremax.org), and/or call Member Services at 1-855-296-8800 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at 1-855-296-8800 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at www.villagecaremax.org.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Member Services at 1-855-296-8800 (TTY users call 711).

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* www.villagecaremax.org or call Member Services at 1-855-296-8800 (TTY users call 711).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through our plan's mail-order service are marked with an NM for Non-Mail Order Drug in our Drug List.

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

To get order forms and information about filling your prescriptions by mail www.villagecaremax.org.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. If your prescription is delayed, call Member Services for Assistance getting your medication.

New prescriptions the pharmacy gets directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it gets 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 can ask for automatic delivery of all new prescriptions at any time by asking your doctor to submit a 90-day-supply prescription to Birdi to start the home delivery service.

If you get a prescription automatically by mail that you don't 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 don't want the pharmacy to automatically fill and ship each new prescription, 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 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 immediately. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, 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.

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

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 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 program that automatically prepares mail-order refills, 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).

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

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

Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* www.villagecaremax.org tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-855-296-8800 (TTY users call 711) for more information
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at 1-855-296-8800 (TTY users call 711)** to see if there's a network pharmacy nearby.

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

- 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

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

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

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

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

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

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. For more information about your Medicaid drug coverage, contact the New York State Medicaid Helpline at 800-541-2831 (TTY 1-800-662-1220).

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

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

Certain drugs may be covered for some medical conditions but considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on Medicare.gov, along with the specific medical conditions that they cover.

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

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

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

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

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 at 1-855-296-8800 (TTY users call 711).

Drugs that aren't on the Drug List

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. For more information about your Medicaid drug coverage, contact the New York State Medicaid Helpline at 800-541-2831 (TTY 1-800-662-1220).

Our plan doesn't cover all prescription drugs.

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

Section 3.2 6 cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic (lowest cost-sharing tier)
- Tier 2 – Generic
- Tier 3 – Preferred Brand
- Tier 4 – Non-Preferred Drug
- Tier 5 – Specialty Tier (highest cost-sharing tier)
- Tier 6 – Select Care Drugs

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

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

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

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (www.villagecaremax.org). The Drug List on the website is always the most current.
- Call Member Services at 1-855-296-8800 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (www.villagecaremax.org) to search for drugs on the Drug List to get an estimate of what you'll pay and

see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-855-296-8800 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-855-296-8800 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-855-296-8800 (TTY users call 711) or on our website www.villagecaremax.org.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 1-855-296-8800 (TTY users call 711) or on our website www.villagecaremax.org.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

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

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

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

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

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

You may be able to get a temporary supply

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

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan**.**
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Member Services at 1-855-296-8800 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-855-296-8800 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can

ask our plan to cover a drug even though it's not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

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

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

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-855-296-8800 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

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

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List**.

- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

Changes to drug coverage that affect you during this plan year

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

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

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

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

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

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open

enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means neither Medicare nor Medicaid pays for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

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

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

In addition, by law, the following categories of drugs listed below aren't covered by Medicare or Medicaid.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program

may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

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

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

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you**. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

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

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

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Pharmacy Directory* www.villagecare.org to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-855-296-8800 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

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

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

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

Special note about creditable coverage:

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

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

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

Section 9.4 If you're in Medicare-certified hospice

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

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

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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

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

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

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

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

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you

disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

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

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

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

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-855-296-8800 (TTY users call 711).

SECTION 11 Your *Part D Explanation of Benefits* explains which payment stage you're in

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

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

Total Drug Costs: this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

Information for that month. This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.

- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable

Section 11.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here 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 make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track

of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**

- When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
- When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
- Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
- If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at 1-855-296-8800 (TTY users call 711). Be sure to keep these reports.

CHAPTER 6:
What you pay for Part D drugs

You pay nothing for Part D drugs covered by our plan.

How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **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, call Member Services at 1-855-296-8800 (TTY users call 711) and ask for the *LIS Rider*.

CHAPTER 7:
Asking us to pay for covered medical services or drugs

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

Our network providers bill our plan directly for your covered services and drugs – you shouldn't get a bill for covered services or drugs. If you get a bill for medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we'll pay the provider directly.

If you already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called **reimburse** 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. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll 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 got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

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

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**
    - You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.

- If you pay the entire amount yourself at the time you get the care, ask us to pay you back. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you made.
    - If the provider is owed anything, we'll pay the provider directly.
    - If you already paid for the service, we'll pay you back.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our 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'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, send us the bill along with documentation of any payment you made. Ask us to pay you back for your covered services.

3. If you're retroactively enrolled in our plan

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

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

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

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

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

enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've 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 got the service, item, or drug.

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

- You don't have to use the form, but it'll help us process the information faster. We need the following information to make a decision:
    - Member Information – Name, Member ID, Address, Telephone Number
    - Service Information – Type of Service, Date of Service, Provider's Name and Contact Information, Total Amount Paid
    - Supporting Documentation – Receipt (proof of payment), Bill or Provider Claim Form listing diagnosis and procedures

- Download a copy of the form from our website www.villagecare.org or call Member Services at 1-855-296-8800 (TTY users call 711) and ask for the form.

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

VillageCareMAX
120 Broadway, Suite 2840
New York, NY 10271

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

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

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

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Albanian, Arabic, Bengali, Chinese, Creole, French, Greek, Italian, Korean, Polish, Russian, Spanish, Tagalog, Urdu, Yiddish, and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-855-296-8800 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with VillageCareMAX Grievances Department at 1-855-296-8800 (TTY: 711). You

can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Seksioni 1.1 Ne duhet t'jua ofrojmë informacionin në një mënyrë të përshtatshme për ju dhe në përputhje me ndjeshmëritë kulturore (në gjuhë të tjera përveç anglishtes, në alfabetin Braille, në shkrim me përmasa të mëdha ose në formate të tjera alternative etj.)

Plani ynë duhet të sigurojë se të gjitha shërbimet, klinike dhe jo klinike, ofrohen në një mënyrë kompetente në aspektin kulturor dhe janë të aksesueshme për të gjithë të regjistruarit, duke përfshirë për personat me njohuri të kufizuara të anglishtes, aftësi të kufizuara leximi, probleme me dëgjimin, ose personat me prejardhje kulturore dhe etnike të ndryshme. Shembujt se si plani ynë mund t'i plotësojë këto kërkesa të aksesueshmërisë përfshijnë, ndër të tjera, ofrimin e shërbimeve të përkthimit, shërbimeve të interpretimit, teleprinterëve ose lidhjes TTY (pajisje telefonike me tekst ose telefon me teleprintim).

Plani ynë disponon shërbime interpretimi pa pagesë për t'ju përgjigjur pyetjeve nga anëtarët që nuk flasin anglisht. Gjithashtu, mund t'ju ofrojmë materiale në gjuhë të tjera përveç anglishtes, duke përfshirë në shqip, arabisht, bengalisht, kinezisht, frëngjisht, kreolishte frënge, greqisht, italisht, koreanisht, polonisht, rusisht, spanjisht, kreolishte spanjolle, tagalogisht, urduisht dhe jidisht, në alfabetin Braille, në shkrim me përmasa të mëdha ose në formate të tjera alternative pa pagesë, nëse ju nevojitet. Ne na kërkohet që t'ju japim informacion rreth përfitimeve të planit tonë në një format që është i aksesueshëm dhe i përshtatshëm për ju. Për të marrë informacion nga ne në një mënyrë të përshtatshme për ju, telefononi "Shërbimet për anëtarët" në numrin 1-855-296-8800 (përdoruesit e TTY-së të telefonojnë në numrin 711).

Plani ynë duhet t'u japë të regjistruarave femra mundësinë për të pasur akses të drejtpërdrejtë te një specialist i shëndetit të grave brenda rrjetit të shërbimeve rutinë dhe parandaluese të kujdesit shëndetësor për gratë.

Nëse në rrjetin e planit tonë nuk ka të disponueshëm ofrues për një specialitet, atëherë është përgjegjësia e planit tonë që të gjejë ofrues të specializuar jashtë rrjetit që do t'ju ofrojnë kujdesin e nevojshëm. Në këtë rast, ju do të paguani vetëm shpenzimet me ndarje kostosh brenda rrjetit. Nëse përballeni me një situatë ku nuk ka specialistë në rrjetin e planit tonë që të mbulojnë një shërbim që ju nevojitet, telefononi planin tonë për informacion se ku mund të shkoni për të marrë këtë shërbim me shpenzime me ndarje kostosh brenda rrjetit.

Nëse hasni vështirësi për të marrë informacion nga plani ynë në një format që është i aksesueshëm dhe i përshtatshëm për ju, për t'u vizituar nga një specialist i shëndetit të grave, apo për të gjetur një specialist në rrjet, telefononi për të paraqitur një ankesë në Departamentin e Ankesave (VillageCareMAX Grievances Department) të VillageCareMAX në numrin 1-855-296-8800 (TTY: 711). Ju mund të paraqitni gjithashtu një ankesë pranë Medicare duke telefonuar në numrin 1-800-MEDICARE (1-800-633-4227), ose drejtpërdrejt pranë Zyrës për të Drejtat Civile (Office for Civil Rights) në numrin 1-800-368-1019, ose me TTY në numrin 1-800-537-7697.

القسم 1.1 يجب أن نوفر المعلومات بطريقة تناسبكم وتتوافق مع حساسيتكم الثقافية (بلغات غير الإنجليزية، أو بطريقة برايل، أو بالطباعة الكبيرة الأحرف، أو أي تنسيقات بديلة أخرى، إلى غير ذلك).

تلتزم خطتنا بضمان تقديم جميع الخدمات، السريرية وغير السريرية، بطريقة تراعي الثقافات المختلفة، وأن تكون هذه الخدمات متاحة لجميع المسجلين، بمن فيهم ذوو الكفاءة المحدودة في اللغة الإنجليزية، أو مهارات القراءة المحدودة، أو الذين يعانون من ضعف السمع، أو ذوي الخلفيات الثقافية والإثنية المتنوعة. تشمل الأمثلة على الأسلوب الذي تتبعه خطتنا في تلبية متطلبات إمكانية الوصول هذه، على سبيل المثال لا الحصر، توفير خدمات الترجمة، وخدمات الترجمة الفورية، والاتصال عبر آلات المراسلة النصية عن بُعد، أو خدمة الهاتف النصي لضعاف السمع (Text Telephone, TTY) أو هاتف المراسلة النصية عن بُعد.

تتوفر في خطتنا خدمات الترجمة الفورية المجانية للإجابة على أسئلة الأعضاء غير الناطقين باللغة الإنجليزية. يمكننا أيضًا تزويدك بمواد بلغات أخرى غير الإنجليزية، بما في ذلك الألبانية، والعربية، والبنغالية، والصينية، والفرنسية، والكريولية الفرنسية، واليونانية، والإيطالية، والكورية، والبولندية، والروسية، والإسبانية، والكريولية الإسبانية، والتاغالوغية، والأردية، واليديشية، وبطريقة برايل، أو بالطباعة الكبيرة الأحرف، أو بتنسيقات بديلة أخرى، وذلك مجانًا عند الحاجة. نحن ملزمون بتزويدك بمعلومات عن مزايا خطتنا بتنسيق يسهل عليك الوصول إليه ويناسبك. للحصول على معلومات منا بطريقة تناسبك، اتصل بخدمات الأعضاء (Member Services) على الرقم 1-855-296-8800 (لمستخدمي أجهزة TTY، يرجى الاتصال على الرقم 711).

تتيح خطتنا للمشتركات خيار الوصول المباشر إلى أخصائي صحة المرأة ضمن شبكتنا للحصول على خدمات الرعاية الصحية الروتينية والوقائية للمرأة.

في حال عدم توفر مقدمي الخدمة ضمن شبكة خطتنا في تخصص ما، تقع على عاتق خطتنا مسؤولية تحديد مقدمي الخدمة في هذا التخصص خارج الشبكة لتقديم الرعاية اللازمة لكِ. في هذه الحالة، لن تدفعين سوى قيمة مشاركة التكلفة داخل الشبكة. إذا وجدتِ نفسك في موقف لم تجدي فيه متخصصين ضمن شبكة خطتنا لتغطية الخدمة التي تحتاجينها، فاتصلي بخطتنا للحصول على معلومات حول الأماكن التي يمكنكِ التوجه إليها للحصول على هذه الخدمة ضمن قيمة مشاركة التكلفة داخل الشبكة.

إذا واجهتِ أي صعوبة في الحصول على معلومات من خطتنا بتنسيق يسهل الوصول إليه ويناسبكِ، أو واجهتِ صعوبة في مراجعة أخصائي صحة المرأة، أو العثور على أخصائي ضمن شبكتنا، فاتصلي لتقديم تظلم لدى قسم التظلمات في VillageCareMAX (VillageCareMAX Grievances Department) على الرقم (TTY: 1-855-296-8800 711). يمكنكِ أيضًا تقديم شكوى لدى Medicare بالاتصال على الرقم 1-800-MEDICARE (1-800-633-4227) أو مباشرةً لدى مكتب الحقوق المدنية (Office for Civil Rights) على الرقم 1-800-368-1019 أو TTY 1-800-537-7697.

বিভাগ 1.1 আমাদের অবশ্যই এমনভাবে তথ্য প্রদান করতে হবে যা আপনার জন্য কার্যকর এবং আপনার সাংস্কৃতিক সংবেদনশীলতার সাথে সামঞ্জস্যপূর্ণ (ইংরেজি ব্যতীত অন্য ভাষায়, ব্রেইল, বড় মুদ্রণ, বা অন্যান্য বিকল্প ফর্ম্যাট ইত্যাদি)।

আমাদের পরিকল্পনার লক্ষ্য হল ক্লিনিক্যাল এবং নন-ক্লিনিক্যাল উভয় ধরণের পরিষেবাই সাংস্কৃতিক দিক থেকে দক্ষভাবে প্রদান করা এবং সকল নথিভুক্ত ব্যক্তির জন্য অ্যাক্সেসযোগ্য হওয়া, যার মধ্যে সীমিত ইংরেজি দক্ষতা, সীমিত পড়ার দক্ষতা, শ্রবণশক্তির অক্ষমতা, অথবা বিভিন্ন সাংস্কৃতিক ও জাতিগত পটভূমির অধিকারী ব্যক্তিরাও অন্তর্ভুক্ত। আমাদের পরিকল্পনা কীভাবে এই অ্যাক্সেসিবিলিটি প্রয়োজনীয়তাগুলি পূরণ করতে পারে তার উদাহরণগুলির মধ্যে রয়েছে, তবে কেবল এগুলির মধ্যেই সীমিত নয় অনুবাদক পরিষেবা, দোভাষী পরিষেবা, টেলিটাইপরাইটার, অথবা TTY (টেক্সট টেলিফোন বা টেলিটাইপরাইটার ফোন) সংযোগ ব্যবস্থা।

আমাদের পরিকল্পনায় ইংরেজি ভাষাভাষী নন এমন সদস্যদের প্রশ্নের উত্তর দেওয়ার জন্য বিনামূল্যে দোভাষী পরিষেবা উপলব্ধ আছে। আমরা আপনাকে ইংরেজি ছাড়া অন্যান্য ভাষায় উপাদান প্রদান করতে পারি, যার মধ্যে রয়েছে আলবেনীয়, আরবি, বাংলা, চীনা, ফরাসি, ফরাসি ক্রেওল, গ্রীক, ইতালীয়, কোরিয়ান, পোলিশ, রাশিয়ান, স্প্যানিশ, স্প্যানিশ ক্রেওল, তাগালগ, উর্দু এবং ইদ্দিশ, ব্রেইল, বড় মুদ্রণে, অথবা আপনার প্রয়োজন হলে অন্যান্য বিকল্প ফর্ম্যাটে। আমাদের পরিকল্পনার সুবিধাগুলি সম্পর্কে আপনাকে এমন একটি ফর্ম্যাটে তথ্য দিতে হবে যা আপনার জন্য অ্যাক্সেসযোগ্য এবং উপযুক্ত। আপনার জন্য কার্যকরী উপায়ে আমাদের কাছ থেকে তথ্য পেতে, সদস্য পরিষেবাগুলিতে 1-855-296-8800 নম্বরে কল করুন (TTY ব্যবহারকারীরা 711 নম্বরে কল করুন)।

আমাদের পরিকল্পনার মধ্যে রয়েছে, নারী নথিভুক্তিদের নিয়মিত এবং প্রতিরোধমূলক স্বাস্থ্যসেবা পরিষেবার জন্য নেটওয়ার্কের মধ্যে একজন নারী স্বাস্থ্য বিশেষজ্ঞের সাথে সরাসরি যোগাযোগের সুযোগ দেওয়া।

যদি আমাদের পরিকল্পনার নেটওয়ার্কের অধীনে কোনো বিশেষায়িত পরিষেবা প্রদানকারী না থাকে, তাহলে নেটওয়ার্কের বাইরের বিশেষায়িত পরিষেবা প্রদানকারীদের খুঁজে বের করা আমাদের পরিকল্পনার দায়িত্ব, যারা আপনাকে প্রয়োজনীয় পরিচর্যা প্রদান করবে। এই ক্ষেত্রে, আপনাকে শুধুমাত্র ইন-নেটওয়ার্ক খরচ ভাগাভাগির জন্য পেমেন্ট করতে হবে। আপনি যদি এমন পরিস্থিতিতে পড়েন যেখানে আমাদের পরিকল্পনার নেটওয়ার্কে আপনার প্রয়োজনীয় পরিষেবা প্রদানকারী কোনো বিশেষজ্ঞ নেই, তাহলে ইন-নেটওয়ার্ক খরচ ভাগাভাগিতে এই পরিষেবাটি কোথায় পেতে হবে সে সম্পর্কে তথ্যের জন্য আমাদের পরিকল্পনায় কল করুন।

যদি আপনার জন্য সহজলভ্য এবং উপযুক্ত ফর্ম্যাটে আমাদের পরিকল্পনা থেকে তথ্য পেতে, মহিলা স্বাস্থ্য বিশেষজ্ঞের সাথে দেখা করতে বা নেটওয়ার্ক বিশেষজ্ঞ খুঁজে পেতে কোনো সমস্যা হয়, তাহলে VillageCareMAX অভিযোগ বিভাগের কাছে 1-855-296-8800 (TTY: 711) নম্বরে অভিযোগ দায়ের করতে কল করুন। আপনি 1-800-MEDICARE (1-800-633-4227) নম্বরে কল করে অথবা সরাসরি নাগরিক অধিকার কার্যালয় (Office for Civil Rights) -এ 1-800-368-1019 নম্বরে অথবা TTY 1-800-537-7697 নম্বরে কল করে Medicare এর কাছে অভিযোগ দায়ের করতে পারেন।

第 1.1 节 我们必须以适合您的方式提供信息，并符合您的文化敏感性（包括英语以外的语言、盲文、大字体或其他替代格式等）

本计划必须确保所有服务（包括临床和非临床）均以文化胜任的方式提供，并确保所有参保人（包括英语水平有限者、阅读能力有限者、听力障碍人士，以及不同文化和种族背景的参保人）都能获得这些服务。本计划满足这些可及性要求的示例包括但不限于：提供翻译服务、口译服务、电传打字机或 TTY（文本电话或电传打字机电话）连接。

本计划提供免费口译服务，协助非英语会员咨询问题。如您需要，我们还可以免费提供非英语的材料，包括阿尔巴尼亚语、阿拉伯语、孟加拉语、中文、法语、法语克里奥尔语、希腊语、意大利语、韩语、波兰语、俄语、西班牙语、西班牙克里奥尔语、他加禄语、乌尔都语和意第绪语版本，以及盲文、大字体或其他替代格式。根据规定，我们须以您可理解且合适的格式向您提供关于本计划福利的信息。如需以适合您的方式获取信息，请拨打会员服务部电话：1-855-296-8800（TTY 用户请拨打 711）。

本计划必须为女性参保人提供直接预约网络内女性健康专科医生的选择，以便获得常规及预防性医疗保健服务。

如果本计划网络内某专科的提供者不可用，本计划有责任寻找网络外的专科提供者为您提供必要医疗服务。此种情况下，您只需支付网络内费用分摊。如果您发现本计划网络内没有专科医生能提供您所需的服务，请打电话给本计划，以获取关于如何以网络内费用分摊标准获得此项服务的信息。

如果您在以可理解且合适的格式获取本计划信息、看诊女性健康专科医生或寻找网络内专科医生方面遇到任何困难，请拨打 1-855-296-8800（TTY：711）向 VillageCareMAX 申诉部门 (Grievances Department) 提出申诉。您也可以拨打 1-800-MEDICARE (1-800-633-4227) 向 Medicare 投诉，或拨打 1-800-368-1019 或 TTY 1-800-537-7697 直接向民权办公室 (Office for Civil Rights) 投诉。

Section 1.1 Nous devons fournir les informations d'une manière qui vous convienne et qui soit adaptée à votre sensibilité culturelle (dans des langues autres que l'anglais, en braille, en gros caractères ou dans d'autres formats, etc.).

Notre régime se doit à garantir que tous les services, cliniques et non cliniques, sont fournis d'une manière respectueuse des différences culturelles et accessibles à tous les adhérents, y compris ceux qui ont une maîtrise limitée de l'anglais, des capacités de lecture limitées, une déficience auditive ou qui proviennent de milieux culturels et ethniques divers. Parmi les exemples illustrant la manière dont notre régime peut répondre à ces exigences en matière d'accessibilité, nous pouvons citer notamment la fourniture de services de traduction et d'interprétation, de téléscripteurs ou d'une connexion à un ATS (terminal texte ou téléscripteur).

Notre régime offre des services d'interprétation gratuits pour répondre aux questions des membres qui ne parlent pas anglais. Nous pouvons également vous fournir gratuitement des documents dans d'autres langues que l'anglais, notamment en albanais, en arabe, en bengali, en chinois, en français, en créole français, en grec, en italien, en coréen, en polonais, en russe, en espagnol, en créole espagnol, en tagalog, en ourdou et en yiddish, en braille, en gros caractères ou dans d'autres formats, si vous en avez besoin. Nous sommes tenus de vous fournir les informations relatives aux prestations de notre régime dans un format accessible et adapté à vos besoins. Pour obtenir ces informations de la manière qui vous convient le mieux, appelez le service aux membres au 1 855 296 8800 (utilisateurs d'un téléscripteur : composez le 711).

Notre régime se doit d'offrir aux adhérentes la possibilité d'accéder directement à un spécialiste de la santé des femmes au sein du réseau de services de soins de santé courants et préventifs destinés aux à celles-ci.

Si aucun prestataire du réseau de notre régime n'est disponible pour une spécialité donnée, il incombe à notre régime de trouver des prestataires spécialisés hors réseau qui vous fourniront les soins dont vous avez besoin. Dans ce cas, vous ne paierez que la participation aux frais prévue dans le réseau. Si vous vous trouvez dans une situation où aucun spécialiste du réseau de notre régime ne prend en charge un service dont vous avez besoin, appelez notre régime pour savoir où vous pouvez obtenir ce service en payant la participation aux frais prévue dans le réseau.

Si vous rencontrez des difficultés pour obtenir des informations sur notre régime dans un format accessible et adapté à vos besoins, pour consulter un spécialiste de la santé des femmes ou pour trouver un spécialiste du réseau, appelez le service des réclamations de VillageCareMAX au 1 855 296 8800 (ATS : 711) afin de déposer une réclamation. Vous pouvez également déposer une réclamation auprès de Medicare en appelant le 1 800 633 4227 ou directement auprès du Bureau des droits civils (Office for Civil Rights) au 1 800 368 1019 (ATS : 1 800 537 7697).

Ενότητα 1.1 Πρέπει να παρέχουμε πληροφορίες με τρόπο που να λειτουργεί για εσάς και να συνάδει με τις πολιτιστικές σας ευαισθησίες (σε άλλες γλώσσες εκτός από τα αγγλικά, σε μορφή μπράιγ, με μεγάλα γράμματα ή με άλλες εναλλακτικές μορφές κ.λπ.)

Το πρόγραμμά μας απαιτείται να διασφαλίζει ότι όλες οι υπηρεσίες, τόσο οι κλινικές όσο και οι μη κλινικές, παρέχονται με πολιτισμικά κατάλληλο τρόπο και είναι προσβάσιμες σε όλους τους εγγεγραμμένους, συμπεριλαμβανομένων ατόμων με περιορισμένη επάρκεια της αγγλικής, περιορισμένες δεξιότητες ανάγνωσης, ανικανότητα ακοής ή ατόμων με διαφορετικό πολιτισμικό και εθνοτικό υπόβαθρο. Παραδείγματα του τρόπου με τον οποίο το σχέδιό μας μπορεί να πληροί αυτές τις απαιτήσεις προσβασιμότητας περιλαμβάνουν, μεταξύ άλλων, την παροχή μεταφραστικών υπηρεσιών, υπηρεσιών διερμηνείας, τηλετυπικών συσκευών ή σύνδεσης TTY (τηλεφώνου γραπτού κειμένου ή πληκτρολόγησης).

Το πρόγραμμά μας διαθέτει δωρεάν υπηρεσίες διερμηνείας για την απάντηση ερωτήσεων που τίθενται από μη αγγλόφωνα μέλη. Μπορούμε επίσης να σας δώσουμε υλικό σε άλλες γλώσσες εκτός από τα αγγλικά, συμπεριλαμβανομένων των αλβανικών, αραβικών, βεγγαλικών, κινεζικών, γαλλικών, κρεολικών γαλλικών, ελληνικών, ιταλικών, κορεατικών, πολωνικών, ρωσικών, κρεολικών ισπανικών, ταγκαλόγκ, ούρντου και γίντις, σε μορφή μπράιγ, με μεγάλα γράμματα ή σε άλλες εναλλακτικές μορφές, χωρίς κόστος, αν το χρειάζεστε. Είμαστε υποχρεωμένοι να σας παρέχουμε πληροφορίες σχετικά με τα προνόμια του προγράμματός μας σε μορφή που είναι προσβάσιμη και κατάλληλη για εσάς. Για να λάβετε πληροφορίες από εμάς με τρόπο που να λειτουργεί για εσάς, καλέστε την Εξυπηρέτηση Πελατών στο 1-855-296-8800 (οι χρήστες TTY καλούν το 711).

Το πρόγραμμά μας απαιτείται να παρέχει στις γυναίκες εγγεγραμμένες τη δυνατότητα άμεσης πρόσβασης σε έναν ειδικό για την υγεία των γυναικών στο πλαίσιο του δικτύου για υπηρεσίες τακτικής και προληπτικής υγειονομικής περίθαλψης των γυναικών.

Αν δεν υπάρχουν διαθέσιμοι πάροχοι στο δίκτυο του προγράμματός μας για μια ειδικότητα, είναι ευθύνη του προγράμματός μας να εντοπίσουμε ειδικούς παρόχους εκτός του δικτύου που θα σας παρέχουν την απαραίτητη φροντίδα. Σε αυτή την περίπτωση, θα πληρώνετε μόνο το ποσό συμμετοχής για συμβεβλημένους παρόχους. Αν βρεθείτε σε μια κατάσταση όπου δεν υπάρχουν ειδικοί στο δίκτυο του προγράμματός μας που να καλύπτουν μια υπηρεσία που χρειάζεστε, καλέστε το πρόγραμμά μας για πληροφορίες σχετικά με το πού να πάτε για να λάβετε αυτή την υπηρεσία, πληρώνοντας μόνο το ποσό συμμετοχής για συμβεβλημένους παρόχους.

Εάν έχετε οποιοδήποτε πρόβλημα να λάβετε πληροφορίες από το πρόγραμμά μας σε μορφή που είναι προσβάσιμη και κατάλληλη για εσάς, να επισκεφθείτε έναν ειδικό για την υγεία των γυναικών ή να βρείτε έναν ειδικό εντός του δικτύου, καλέστε για να υποβάλετε παράπονο στο Τμήμα Παραπόνων VillageCareMAX στο 1-855-296-8800 (TTY: 711). Μπορείτε επίσης να υποβάλετε καταγγελία στην Medicare καλώντας στο 1-800-MEDICARE (1-800-633-4227) ή απευθείας στο Γραφείο Πολιτικών Δικαιωμάτων 1-800-368-1019 ή στο TTY 1-800-537-7697.

Seksyon 1.1 Nou dwe bay enfòmasyon yon jan ki bon pou ou epi ki adapte ak sansibilite kiltirèl ou yo (nan lòt lang ki pa Anglè, bray, gwo karaktè oswa lòt fòma altènatif yo, elatriye.)

Plan nou yo dwe garanti tout sèvis yo, alafwa sa ki klinik ak sa ki pa klinik bay nan respè diferans kiltirèl yo epi aksesib ak tout moun ki enskri yo, san wete sila yo ki pa fin konprann Anglè, ki limite nan kapasite yo pou li, ki pa gen kapasite pou yo tande oswa ki soti nan kilti ak etni diferan. Egzanp sou fason plan nou an kapab reponn ak egzijans aksesiblite sa yo ki gen ladan, men ki pa limite nan kesyon bay sèvis tradiksyon, sèvis entèpretasyon, teleskriptè oswa koneksyon TTY (telefòn tèks oswa telefòn teleskriptè).

Plan nou an genyen sèvis entèprèt gratis disponib pou reponn kesyon manm ki pa pale Anglè yo. Nou kapab ba w materyèl gratis tou nan lòt lang ki pa Anglè tankou Albanè, Arab, Bengali, Chinwa, Fransè, Kreyòl Fransè, Grèk, Italyen, Koreyen, Polonè, Ris, Payòl, Kreyòl Panyòl, Tagalòg, Oudou ak Yidich, an bray, gwo karaktè oswa lòt fòma altènatif yo si w gen bezwen pou sa. Nou gen responsablite pou ba w enfòmasyon sou avantaj plan nou yo nan yon fòma ki aksesib epi ki apwopriye pou ou. Pou ou jwenn enfòmasyon nan men nou nan yon fason ki bon pou ou, rele Sèvis pou Manm yo nan 1-855-296-8800 (moun ki sèvi ak TTY yo rele 711).

Plan nou an gen obligasyon pou bay fanm ki enskri yo posiblite pou gen aksè dirèk ak yon espesyalis sante pou fanm anndan rezo a pou sèvis swen sante woutin ak prevantif fanm yo.

Si founisè espesyalize ki nan rezo plan an pa disponib, se responsabilite plan nou an pou jwenn founisè espesyalize an deyò rezo a pou bay swen nesesè yo. Nan ka sa a, w ap sèlman peye frè pataje pou sèvis yo bay nan rezo a. Si ou ta nan yon sitiyasyon kote pa gen espesyalis nan rezo plan niu an ki kouvri sèvis ou bezwen an, rele plan nou an pou w jwenn enfòmasyon sou kote pou w jwenn sèvis sa a ak yon frè pataje ki koresponn ak rezo a.

Si ou gen difikilte pou jwenn enfòmasyon nan plan nou an nan yon fòma ki aksesib epi ki apwopriye pou ou, konsilte yon espesyalis sante pou fanm oswa jwenn yon espesyalis nan rezo a, rele pou depoze yon doleyans nan Depatman Doleyans VillageCareMAX nan 1-855-296-8800 (TTY: 711). Ou ka depoze yon plent tou nan Medicare pandan w ap rele 1-800-MEDICARE (1-800-633-4227) oswa dirèkteman nan Biwo Dwa Sivil la 1-800-368-1019 oswa TTY 1-800-537-7697.

Sezione 1.1 Siamo tenuti a fornire le informazioni nei modi più appropriati per il paziente e conformemente alla sua sensibilità culturale (in lingue diverse dall'inglese, in formato Braille, con caratteri grandi o in altri formati alternativi, e così via).

Il nostro piano è tenuto ad assicurare che tutte le prestazioni, sia cliniche che non cliniche, vengano fornite in maniera culturalmente competente e siano accessibili a tutti gli iscritti, compresi quanti hanno conoscenza e capacità di lettura limitate nella lingua inglese, problemi di ascolto o coloro che hanno con un bagaglio culturale ed etnico diverso. Tra le modalità di risposta del piano a questi requisiti di accessibilità vi sono, a titolo esemplificativo ma non esclusivo, la fornitura di servizi di traduzione e interpretariato, servizi di telescrittura o la connessione TTY (trasmissione telefonica di testi o in telescrittura).

Il piano mette a disposizione servizi di interpretariato gratuiti per rispondere alla domande degli utenti che non parlano inglese. All'occorrenza, possono essere forniti gratuitamente materiali in lingue diverse dall'inglese, tra cui albanese, arabo, bengalese, cinese, coreano, creolo francese, creolo spagnolo, greco, francese, italiano, polacco, russo, spagnolo, tagalog, urdu e yiddish, in formato Braille, con caratteri grandi o in altri formati alternativi. Siamo tenuti a fornire informazioni sui vantaggi del piano in un formato accessibile e appropriato all'utente. Per ricevere informazioni nei modi più appropriati, contattare i Servizi per gli iscritti all'1-855-296-8800 (gli utenti TTY contattino il 711).

Il piano è tenuto a offrire alle iscritte l'opportunità di accesso diretto a uno specialista nell'ambito della rete di servizi per la routine e la prevenzione della salute della donna.

In caso di indisponibilità di specialisti convenzionati con il piano, spetterà al piano stesso individuare al di fuori della rete convenzionata gli specialisti che forniranno le cure necessarie all'utente. In questo caso, all'utente spetterà versare solo la quota di partecipazione alla rete convenzionata. Se l'utente si ritrova nella situazione in cui nessuno specialista convenzionato al piano può fornire la prestazione di cui ha bisogno, dovrà chiedere al piano da chi ottenere tale prestazione al costo di partecipazione alla rete convenzionata.

In caso di difficoltà a ottenere dal piano le informazioni nel formato più accessibile e appropriato al proprio caso o a consultare uno specialista della salute femminile o a trovare uno specialista convenzionato, chiamare l'1-855-296-8800 (TTY: 711) per presentare un reclamo all'Ufficio reclami di VillageCareMAX. È possibile presentare reclamo anche a Medicare chiamando l'1-800-633-4227 o rivolgendosi direttamente all'Ufficio per i diritti civili all'1-800-368-1019 (TTY 1-800-537-7697).

섹션 1.1 당사는 귀하에게 적합하고 귀하의 문화적 감수성에 부합하는 방법으로 정보를 제공할 의무가 있습니다(영어 외의 언어, 점자, 큰 활자, 그 외의 대안 형식 등)

당사 플랜은 모든 임상 및 비임상 서비스를 문화적으로 적절한 방식으로 제공하고, 영어 능력이 제한적이거나 읽기 능력이 부족하거나 청각 장애가 있거나 다양한 문화적 및 민족적 배경을 가진 모든 가입자가 이용할 수 있도록 보장해야 합니다. 당사 플랜이 이러한 접근성 요건을 충족할 수 있는 예로는 번역 서비스, 통역 서비스, 텔레타이프라이터, TTY(텍스트텔레폰 또는 텔레타이프라이터폰) 연결 등을 포함하되 이에 국한되지 않습니다.

당사 플랜은 영어 외의 언어를 구사하는 회원의 질문에 답할 수 있도록 무료 통역 서비스를 운영하고 있습니다. 또 요청이 있을 경우, 영어가 아닌 언어(알바니아어, 아랍어, 벵골어, 중국어, 프랑스어, 프랑스 크리올어, 그리스어, 이탈리아어, 한국어, 폴란드어, 러시아어, 스페인어, 스페인 크리올어, 타갈로그, 우르두어, 이디시어 등), 점자, 큰 활자, 그 외의 대안 형식으로 된 자료를 무료 제공할 수 있습니다. 당사는 플랜의 혜택에 대한 정보를 귀하가 이해할 수 있고 귀하에게 적합한 형식으로 제공해야 합니다. 적합한 방식으로 정보를 얻고자 한다면, 1-855-296-8800(TTY 사용자는 711)으로 회원 서비스에 전화하십시오.

당사 플랜은 여성 가입자가 네트워크 내 여성 건강 전문가에게 직접적으로 여성 일반 및 예방 의료 서비스를 받을 수 있도록 선택지를 제공해야 합니다.

플랜 네트워크 내에서 특정 전문 분야의 의료제공자를 이용할 수 없을 경우, 당사 플랜은 귀하에게 필요한 의료를 제공할 네트워크 외부 의료제공자를 찾을 책임이 있습니다. 이 경우 귀하는 네트워크 내 본인 분담 비용만을 부담합니다. 플랜 네트워크에 귀하에게 필요한 서비스를 제공하는 전문의가 없는 상황이라면, 당사 플랜에 연락해 네트워크 내 본인 분담 비용으로 해당 서비스를 받을 수 있는 곳에 대한 정보를 얻으십시오.

당사 플랜에서 귀하가 이해할 수 있고 귀하에게 적합한 방식으로 정보를 얻거나, 여성 건강 전문가의 진료를 받거나, 네트워크 내 전문가를 찾는 데 어려움이 있을 경우, VillageCareMAX 고충 부서에 1-855-296-8800(TTY: 711)으로 전화해서 고충을 제기하십시오. 1-800-MEDICARE(1-800-633-4227)로 전화해서 Medicare 에 불만을 제기하거나, 1-800-368-1019 또는 TTY 1-800-537-7697 로 민권 사무소(Office for Civil Rights)에 직접 불만을 제기할 수도 있습니다.

Sekcja 1.1 Musimy udostępniać informacje w sposób, który jest dla Pani wygodny i zgodny z Pani wrażliwością kulturową (w językach innych niż angielski, w alfabecie Braille'a, dużym druku lub w innych alternatywnych formatach itd.).

Nasz plan musi zagwarantować, że wszystkie usługi, zarówno kliniczne, jak i pozakliniczne, będą świadczone w sposób uwzględniający różnice kulturowe i będą dostępne dla wszystkich uczestników, w tym osób o ograniczonej znajomości języka angielskiego, ograniczonych umiejętnościach czytania, niedosłyszących lub pochodzących z różnych środowisk kulturowych i etnicznych. Przykładami sposobów spełnienia przez nasz plan tych wymagań dotyczących dostępności są m.in. zapewnienie usług tłumaczeń pisemnych, usług tłumaczeń ustnych, teleksu lub połączeń TTY (telefonów tekstowych lub telefonów z teleksem).

W ramach naszego planu zapewniamy bezpłatne usługi tłumaczy ustnych, którzy odpowiedzą na pytania członków nie mówiących po angielsku. W razie potrzeby możemy udostępnić Pani bezpłatne materiały w innych językach niż angielski, w tym w języku albańskim, arabskim, bengalskim, chińskim, francuskim, greckim, hiszpańskim, jidysz, koreańskim, kreolskim francuskim, kreolskim hiszpańskim, polskim, rosyjskim, tagalskim, urdu, włoskim, w alfabecie Braille'a, dużym drukiem lub w innych alternatywnych formatach. Jesteśmy zobowiązani do przekazania Pani informacji o korzyściach wynikających z naszego planu w formacie, który będzie dla Pani przystępny i odpowiedni. Aby uzyskać od nas informacje w sposób, który Pani odpowiada, należy zadzwonić do działu obsługi klienta pod numer 1-855-296-8800 (użytkownicy TTY mogą dzwonić pod numer 711).

Nasz plan jest zobowiązany do zapewnienia zapisanym kobietom możliwości bezpośredniego dostępu do specjalisty zajmującego się zdrowiem kobiet w ramach sieci w celu świadczenia rutynowych i profilaktycznych usług opieki zdrowotnej dla kobiet.

Jeśli w sieci naszego planu nie ma dostępnych specjalistów, nasz plan ma obowiązek znaleźć specjalistów spoza sieci, którzy zapewnią Pani niezbędną opiekę. W tym przypadku opłaci Pani wyłącznie udział w kosztach w ramach sieci. Jeśli znajdzie się Pani w sytuacji, w której w sieci naszego planu nie ma specjalistów świadczących potrzebne usługi, należy zadzwonić do naszego planu, aby dowiedzieć się, gdzie można skorzystać z takiej usługi w ramach udziału w kosztach w ramach sieci.

W razie jakichkolwiek trudności z uzyskaniem informacji z naszego planu w formacie, który jest dla Pani dostępny i odpowiedni, ze skontaktowaniem się ze specjalistą ds. zdrowia kobiet lub ze znalezieniem specjalisty sieci należy zadzwonić pod numer 1-855-296-8800 (TTY: 711), aby złożyć skargę do działu skarg VillageCareMAX Można również złożyć skargę do Medicare, dzwoniąc pod numer 1-800-MEDICARE (1-800-633-4227) lub bezpośrednio do Biura Rzecznika Praw Obywatelskich pod numer 1-800-368-1019 lub TTY 1-800-537-7697.

Раздел 1.1 Предоставление информации в удобном для вас формате с учетом культурных особенностей (на других языках, шрифтом Брайля, крупным шрифтом или в других альтернативных форматах)

Наш план должен гарантировать, что все услуги, как клинические, так и неклинические, предоставляются с учетом культурных особенностей и доступны для всех участников, включая лиц с ограниченным знанием английского языка, низкими навыками чтения, нарушениями слуха, а также представителей различных культурных и этнических групп. Примеры того, как наш план может соответствовать этим требованиям доступности, включают, помимо прочего, предоставление услуг переводчика (письменного и устного), телетайпа или подключения через TTY (текстовый телефон или телетайп).

В рамках нашего плана предоставляются бесплатные услуги устного переводчика, чтобы участники, не говорящие на английском языке, могли получить ответы на интересующиеся вопросы. Мы также можем бесплатно (если это необходимо) предоставить вам материалы на языках, отличных от английского, включая албанский, арабский, бенгальский, китайский, французский, французский креольский, греческий, итальянский, корейский, польский, русский, испанский, испанский креольский, тагальский, урду и идиш, а также шрифтом Брайля, крупным шрифтом или в других альтернативных форматах. Мы обязаны предоставить вам информацию о страховых выплатах и преимуществах нашего плана в формате, который является для вас доступным и подходящим. Чтобы получить информацию в удобном для вас виде, позвоните в службу поддержки участников по номеру 1-855-296-8800 (пользователям TTY следует звонить по номеру 711).

Мы обязаны предоставить женщинам, зарегистрированным в нашем плане, возможность прямого обращения к специалисту по женскому здоровью в рамках сети для оказания плановых и профилактических медицинских услуг.

Если в сети нет поставщиков нужного профиля, наш план несет ответственность за поиск специализированных специалистов за пределами сети, которые предоставят вам необходимую помощь. В этом случае вы будете платить только за долевое участие в расходах в рамках сети. Если вы оказались в ситуации, когда в сети нашего плана нет специалистов, предоставляющих необходимую вам услугу, свяжитесь с администрацией, чтобы узнать, куда обратиться за этим медицинским обслуживанием с оплатой на условиях сети.

Если у вас возникнут трудности с получением информации от нашего плана в доступном и подходящем для вас формате, с посещением специалиста по женскому здоровью или с поиском специалиста из нашей сети, позвоните в Отдел жалоб (Grievances Department) от VillageCareMAX по номеру 1-855-296-8800 (TTY: 711). Кроме того, вы вправе подать жалобу в Medicare, набрав 1-800-MEDICARE (1-800-633-4227), либо позвонив в Управление защиты гражданских прав (Office for Civil Rights) по номеру 1-800-368-1019 (TTY: 1-800-537-7697).

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

Nuestro plan es necesario para garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de una manera culturalmente competente y sean accesibles para todos los afiliados, incluyendo quienes tienen dominio limitado del inglés, competencias de lectura limitadas, discapacidad auditiva o diversos orígenes culturales y étnicos. Los ejemplos de cómo nuestro plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traductor, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teléfono de teletipo).

Nuestro plan cuenta con servicios de interpretación gratis disponibles para responder preguntas de miembros que no hablan inglés. También podemos darle materiales en otros idiomas además del inglés, incluyendo albanés, árabe, bengalí, chino, francés, criollo francés, griego, italiano, coreano, polaco, ruso, español, criollo español, tagalo, urdu y yiddish, braille, en letra grande u otros formatos alternativos sin costo si lo necesita. Estamos obligados a darle información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros al 1-855-296-8800 (los usuarios de TTY deben llamar al 711).

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

Si los proveedores de la red de nuestro plan para una especialidad no están disponibles, es responsabilidad de nuestro plan encontrar proveedores especializados fuera de la red que le den la atención necesaria. En este caso, solo pagará costos compartidos dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran un servicio que necesita, llame a nuestro plan para obtener información sobre dónde ir para obtener este servicio con costos compartidos dentro de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, consultar a un especialista en salud de la mujer o encontrar un especialista de la red, llame para presentar una queja formal ante el Departamento de Quejas Formales (Grievances Department) de VillageCareMAX al 1-855-296-8800 (TTY: 711). También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente con la Oficina para Derechos Civiles (Office for Civil Rights) al 1-800-368-1019 o TTY 1-800-537-7697.

Seksyon 1.1 Dapat naming ibigay ang impormasyon sa paraang angkop sa iyo at naaayon sa iyong kultural na pagpapahalaga (sa mga wika maliban sa Ingles, braille, malalaking print, o iba pang alternatibong format, atbp.)

Iniatas sa aming plano na tiyakin na lahat ng serbisyo, klinikal man o hindi klinikal, ay ibinibigay sa paraang may kultural na kahusayan at madaling ma-access ng lahat ng nakatala, kabilang ang mga may limitadong kasanayan sa Ingles, limitadong kakayahan sa pagbasa, kapansanan sa pandinig, o iba't ibang kultural at etnikong pinagmulan. Kabilang sa mga halimbawa kung paano matutugunan ng aming plano ang mga kinakailangan sa accessibility, ngunit hindi limitado sa, pagbibigay ng serbisyo ng tagasalin, serbisyo ng interpreter, mga teletypewriter, o koneksyon sa TTY (text telephone o teletypewriter phone).

Ang aming plano ay may mga libreng serbisyo ng interpreter para sagutin ang mga tanong mula sa mga miyembrong hindi nagsasalita ng Ingles. Makakapagbigay rin kami sa iyo ng mga materyal sa mga wika maliban sa Ingles, kabilang ang Albanian, Arabic, Bengali, Chinese, French, French Creole, Greek, Italian, Korean, Polish, Russian, Spanish, Spanish Creole, Tagalog, Urdu, at Yiddish, gayundin sa braille, malalaking print, o iba pang alternatibong format, nang walang bayad kung kailangan mo ito. Iniatas sa amin na ibigay sa iyo ang impormasyon tungkol sa mga benepisyo ng aming plano sa format na madaling ma-access at angkop para sa iyo. Para makakuha ng impormasyon mula sa amin sa paraang angkop para sa iyo, tawagan ang Member Services (Mga Serbisyo para sa Miyembro) sa 1-855-296-8800 (tumawag sa 711 ang mga gumagamit ng TTY).

Iniatas sa aming plano na bigyan ang mga babaeng nakatala ng opsyon na magkaroon ng direktang access sa espesyalista sa kalusugan ng kababaihan sa loob ng network para sa mga regular at pang-iwas na serbisyong pangangalagang pangkalusugan ng kababaihan.

Kung walang makukuhang mga provider para sa isang espesyalidad sa network ng aming plano, responsibilidad ng aming plano na maghanap ng mga espesyalistang provider sa labas ng network na magbibigay sa iyo ng kinakailangang pangangalaga. Sa kasong ito, magbabayad ka lamang ng in-network na pagbabahagi ng gastos. Kung nasa sitwasyon ka na walang espesyalista sa network ng aming plano na nagbibigay ng serbisyong kailangan mo, tawagan ang aming plano para humingi ng impormasyon kung saan ka maaaring pumunta para makuha ang serbisyong ito sa halaga ng in-network na pagbabahagi ng gastos.

Kung nagkakaproblema ka sa pagkuha ng impormasyon mula sa aming plano sa anyong madaling ma-access at angkop para sa iyo, sa pagkonsulta sa espesyalista sa kalusugan ng kababaihan, o sa paghahanap ng espesyalista sa network, tumawag para magsumite ng reklamo sa VillageCareMAX Grievances Department (Departamento ng mga Reklamo ng VillageCareMAX) sa 1-855-296-8800 (TTY: 711). Maaari ka ring maghain ng reklamo sa Medicare sa pamamagitan ng pagtawag sa 1-800-MEDICARE (1-800-633-4227) o direkta sa Office for Civil Rights (Tanggapan para sa mga Karapatang Sibil) sa 1-800-368-1019 o TTY sa 1-800-537-7697.

سیکشن 1.1 ہم پر معلومات ایسے انداز میں فراہم کرنا لازم ہے جو آپ کے لیے کارگر ہو اور آپ کی ثقافتی حساسیتوں سے ہم آہنگ ہو (انگریزی کے علاوہ زبان، بریل، بڑے پرنٹ، یا دیگر متبادل فارمیٹس، وغیرہ)

ہمارا پلان یہ یقینی بنانے کے لیے مطلوب ہے کہ سبھی خدمات، طبی اور غیر طبی دونوں ہی، ثقافتی لحاظ سے مجاز انداز میں فراہم کی جاتی ہیں اور سبھی اندراج یافتگان، بشمول انگریزی کی محدود مہارت، مطالعہ کی محدود اہلیتیں، سماعت کی عدم صلاحیت، اور متنوع ثقافتی اور نسلی پس منظر والوں کے لیے قابل رسائی ہیں۔ ہمارا پلان رسائی پذیری کے تقاضوں کو جس طریقے سے پورا کر سکتا ہے اس کی مثالوں میں مترجم کی خدمات، ترجمانی کی خدمات، ٹیلی ٹائپ رائٹرز، یا TTY (ٹیسکٹ ٹیلیفون یا ٹیلی ٹائپ رائٹر ون) کنکشن بلا تحدید شامل ہیں۔

ہمارے پلان میں مفت ترجمانی کی خدمات غیر انگریزی داں ممبروں کی طرف سے سوالوں کا جواب دینے کے لیے دستیاب ہیں۔ اگر آپ کو ضرورت پڑی تو ہم آپ کو مواد انگریزی کے علاوہ زبانوں بشمول البانی، عربی، بنگالی، چینی، فرانسیسی، فرانسیسی کریول، یونانی، اطالوی، کورین، پولش، روسی، ہسپانوی، ہسپانوی کریول، ٹیگالوگ، اردو اور یدش، بریل، بڑے پرنٹ میں، یا دیگر متبادل فارمیٹس میں بغیر لاگت کے بھی دے سکتے ہیں۔ ہم سے ہمارے پلان کی فوائد کے بارے میں معلومات ایسے فارمیٹ میں دینے کا تقاضا کیا جاتا ہے جو آپ کے لیے قابل رسائی اور مناسب ہو۔ آپ کے لیے کارگر ہونے والے انداز میں ہم سے معلومات حاصل کرنے کے لیے، ممبر سروسز کو 1-855-296-8800 پر کال کریں (TTY صارفین 711 پر کال کریں)۔

ہمارا پلان زنانہ اندراج یافتگان کو خواتین کی معمول کی اور تدارکی نگہداشت خدامت کے مدنظر نیٹ ورک میں شامل زنانہ صحت کے ماہرین تک براہ راست رسائی کا اختیار دینے کے لیے مطلوب ہے۔

اگر تخصیص کے مدنظر ہمارے پلانے کے نیٹ ورک میں شامل فراہم کنندگان دستیاب نہ ہوں تو، نیٹ ورک سے باہر تخصیصی فراہم کنندگان کی نشاندہی کرنا ہمارے پلان کی ذمہ داری ہے جو آپ کو لازمی نگہداشت فراہم کریں گے۔ اس معاملے میں، آپ صرف درون نیٹ ورک لاگت کی حصہ داری ادا کریں گے۔ اگر آپ خود کو ایسی صورتحال میں پاتے ہیں جہاں ہمارے پلان کے نیٹ ورک میں کوئی ایسا اسپیشلٹ نہ ہو جو آپ کو درکار خدمت کا احاطہ کرتا ہو تو، اس بارے میں معلومات کے لیے ہمارے پلان کو کال کریں کہ درون نیٹ ورک لاگت میں حصہ داری میں یہ خدمات حاصل کرنے کے لیے کہاں جائیں۔

اگر آپ کو ہمارے پلان کے بارے میں معلومات آپ کے لیے قابل رسائی اور مناسب فارمیٹ میں حاصل کرنے، زنانہ صحت کی اسپیشلسٹ کو دکھانے یا نیٹ ورک اسپیشلٹ کو تلاش کرنے میں کوئی پریشانی ہو تو، VillageCareMAX گریوانسز ڈپارٹمنٹ (VillageCareMAX Grievances Department) کے پاس 1-855-296-8800 (TTY: 711) شکایت درج کرانے کے لیے کال کریں۔ آپ Medicare کے پاس براہ راست 1-800-MEDICARE (1-800-633-4227) پر کال کر کے یا براہ راست دفتر برائے دیوانی حقوق (Office for Civil Rights) کے پاس 1-800-368-1019 یا TTY 1-800-537-7697 پر شکایت درج کرا سکتے ہیں۔

אפטיילונג 1.1 מיר מוזן צושטעלן אינפארמאציע אין א וועג וואס איז פאסיג פאר אייך און קומט נאך אייערע קולטורישע סענסעטיוויטעטן (אין שפראכן אויסער ענגליש, ברעיל, גרויסע דרוק אדער אנדערע פארמאטן, א.ד.ג.)

אונזער פלאן איז געפאדערט צו פארזיכערן אז אלע סערוויסעס, סיי קלינישע און נישט-קלינישע, ווערן צוגעשטעלט אויף א קולטור פעאיגע פארנעם און זענען צוגענגליך פאר אלע איינגעשריבענע, אריינגערעכנט די מיט באגרעניצטע ענגליש קענטעניס, באגרעניצטע ליינען מעגליכקייטן, הערן באגרעניצונג אדער די מיט פארשידנארטיגע קולטורישע און עטנישע אפשטאמען. ביישפילן פון וויאזוי אונזער פלאן קען נאכקומען די צוגענגליכקייט פאדערונגען נעמען אריין, אבער זענען נישט באגרעניצט צו צושטעלן איבערזעצונג סערוויסעס, דאלמעטשינג סערוויסעס, טעלעטייפריייטערס, אדער TTY (טעקסט טעלעפאן אדער טעלעטייפריייטער טעלעפאן) פארבינדונג.

אונזער פלאן האט גרייטע דאלמעטשינג סערוויסעס צוגעשטעלט אומזיסט צו ענטפערן פראגעס פון נישט-ענגליש שפרעכנדע מיטגלידער. מיר קענען אייך אויך געבן אינפארמאציע אין שפראכן אויסער ענגליש אריינגערעכנט אלבאניש, אראביש, בענגאליש, כינעזיש, פראנצויזיש, פראנצויזיש קרעאליש, גריכיש, איטאליענישן, קארעיש, פוילישן, רוסישן, ספאניש, ספאניש קרעאליש, טאגאלאג, אורדו, און אידיש, ברעיל, אין גרויסע דרוק, אדער אנדערע פארמאטן אן קיין אפצאל אויב איר דארפט עס. מיר זענען געפאדערט אייך צו געבן אינפארמאציע איבער אונזער פלאן'ס בענעפיטן אויף א וועג וואס איז צוגענגליך און פאסיג פאר אייך. צו באקומען אינפארמאציע פון אונז אויף א וועג וואס איז פאסיג פאר אייך, רופט מיטגלידער סערוויסעס אויף 1-855-296-8800 (TTY באנוצער רופט 711).

אונזער פלאן איז געפאדערט צו געבן פאר פרויען אייגעשריבענע די אויסוואל פון דירעקטע צוטריט צו א פרויען'ס העלט ספעציאליסט אין די נעטווארק פאר פרויען'ס געווענליכע און פארמיידנדע העלט קעיר סערוויסעס.

אויב פראוויידערס אין אונזער פלאן'ס נעטווארק פאר א ספעציעלע פעלד זענען נישט אוועילעבל, איז עס די פלאן'ס פראנטווארטליכקייט צו טרעפן ספעציעלע פראוויידערס אינדרויסן פונעם נעטווארק וואס וועלן אייך צושטעלן די נויטיגע קעיר. אין אזא פאל, וועט איר נאר באצאלן די טייל וואס איר דארפט באצאלן פון אן אין-נעטווארק סערוויס. אויב איר טרעפט זיך אין א צושטאנד וואו עס איז נישט דא קיין ספעציאליסטן אין אונזער פלאן'ס נעטווארק וועלכע דעקן א סערוויס וואס איר דארפט, זאלט איר רופן אונזער פלאן פאר אינפארמאציע אויף וואו צו גיין צו באקומען די סערוויס פאר די פרייז פונעם אין-נעטווארק טייל וואס איר דארפט באצאלן.

אויב איר האט שווערigקייטן מיט באקומען אינפארמאציע פון אונזער פלאן אויף א וועג וואס איז צוגענגליך און פאסיג פאר אייך, צו זען א פרויען'ס העלט ספעציאליסט אדער טרעפן א נעטווארק ספעציאליסט, דאן רופט אריינצוגעבן א קלאגע מיט VillageCareMAX אנקלאגעס דעפארטמענט אויף 1-855-296-8800 (TTY: 711). איר קענט אויך אריינגעבן א קלאגע מיט Medicare דורך רופן 1-800-633-4227 אדער דירעקט צום אפיס פון ציווילע רעכטן 1-800-368-1019 אדער 1-800-537-7697 TTY.

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

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. We don't require you to get referrals to go to network providers.

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

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we 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's been shared with others

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-855-296-8800 (TTY users call 711).

Visit www.villagecaremax.org for our Notice of Privacy Practices.

Section 1.4 We must give you information about our plan, our 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, call Member Services at 1-855-296-8800 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical

service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

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

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

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

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-855-296-8800 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with New York State Department of Health.

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

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

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

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

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

- **Call our plan's Member Services at 1-855-296-8800 (TTY users call 711)**
- **Call your local SHIP** at 1-800-701-0501
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-855-296-8800 (TTY users call 711)**
- **Call your local SHIP** at 1-800-701-0501
- **Contact Medicare**
    - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-855-296-8800 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.
    - Chapters 5 and 6 give details about Part D drug coverage.

- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors 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 you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you're responsible for these payments:
    - You must continue to pay your Medicare premiums to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you're 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 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-855-296-8800 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't 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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You can call New York State Health Insurance Information, Counseling, and Assistance (HIICAP) at 1-800-701-0501.

Medicare

You can also contact Medicare for help:

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

You can get help and information from Medicaid

Call New York State Medicaid Program at 800-541-2831 or visit the website www.health.ny.gov/health_care/medicaid/.

SECTION 3 Understanding Medicare and Medicaid complaints and appeals

You have Medicare and get help from Medicaid. Information in this chapter applies to **all** your Medicare and Medicaid benefits. This is called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes aren't combined. In those situations, 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**.

SECTION 4 Which process to use for your problem

If you have a problem or concern, 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 drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11**, **How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

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

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7 of this chapter.

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

Section 5.1 Get help asking for a coverage decision or making an appeal

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

- **Call Member Services at** 1-855-296-8800 (TTY users call 711)
- **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 need to be appointed as your representative. Call Member Services at 1-855-296-8800 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).
    - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
    - If your doctor or other health provider asks that a service or item that you're 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 drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

If you want a friend, relative, or other person to be your representative, call Member Services *at 1-855-296-8800 (TTY users call 711) and* ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and the person you want to act on your behalf. You must give us a copy of the signed form.

We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

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

- **Section 6:** "Medical care: How to ask for a coverage decision or make an appeal"
- **Section 7:** "Part D drugs: How to ask for a coverage decision or make an appeal"
- **Section 8:** "How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon"
- **Section 9:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-855-296-8800 (TTY users call 711). You can also get help or information from your SHIP.

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

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for your care

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

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

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got 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're told that coverage for certain medical care you've been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 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, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination**.

A **fast coverage decision** is called an **expedited determination**.

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs.

- 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'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request **for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days** after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no.

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

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

Section 6.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

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

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

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a 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'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll 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'll also keep getting all other services or items (that aren't 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 the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we'll send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 The Level 2 appeal process

Legal Term:

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

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

- If your problem is about a service or item that's usually **covered by Medicare**, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.

- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

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

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B

drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization
- **If the independent review 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 shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Tells you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go 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 an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: Ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within** 60 **calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

You can ask for a Fair Hearing with the state:

- **By Phone:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)
- **By Fax:** 518-473-6735
- **By Internet:** http://otda.ny.gov/oah/FHReq.asp
- **By Mail:**
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
- **In Person:**
  For non-New York City residents:
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  40 North Pearl Street
  Albany, New York 12243

  For New York City residents:
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  5 Beaver Street
  New York, New York 10004

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong. If the State denies your request for a fast track Fair Hearing, they will call you and send you a letter. If your request for a fast track Fair Hearing is denied, the State will process your Fair Hearing in 90 days.

If the State approves your request for a fast track Fair Hearing, they will call you to give you the time and date of your hearing. All Fast Track Fair Hearings will be held by phone.

To prepare for the hearing:

- **We will send you a copy of the "evidence packet" before the hearing.** This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call 1-855-296-8800 (TTY: 711) to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call 1-855-296-8800 (TTY: 711) to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing,** like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org. In New York City, call 311.

External Appeal

You have other appeal rights if we said the service you asked for was:

- not medically necessary;
- experimental or investigational;
- 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.

For these types of decisions, you can ask New York State (NYS) for an independent External Appeal. This is called an External Appeal because it is decided by reviewers who do not work for VillageCareMAX or NYS. These reviewers are qualified people approved by NYS. The service

must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.
You have **4 months** from the date that we sent the decision letter on your Level 1 appeal to ask for an External Appeal. If you and VillageCareMAX agreed to skip our 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 1-855-296-8800 (TTY: 711) if you need help filing an External 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 External Appeal application:
- Call the Department of Financial Services at 1-800-400-8882
- Go to the Department of Financial Services' website.
- Contact us at 1-855-296-8800 (TTY: 711)

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and VillageCareMAX will be told the final decision within two days after the decision is made.

You can get a faster decision if:
- Your doctor says that a delay will cause serious harm to your health; or
- You are in the hospital after an emergency room visit and the hospital care is denied by your plan.

This is called an Expedited External Appeal. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:
- you ask for a fast track Level 1 appeal within 24 hours, **AND**
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Level 1 appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing **and** an External Appeal, the decision of the fair hearing officer will be the one that counts.

Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal.**)

If the decision is no for all or part of what you asked for, you can make another appeal.

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section 10** for more information on your appeal rights after Level 2.

Section 6.5 If you're asking us to pay you back for a bill you got for medical care

If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's 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 already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll 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're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, ask us to make this coverage decision. We'll check to see if the medical care you paid for is a covered service. We'll 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 the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- **If we say no to your request:** If the medical care isn't covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we'll not pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the health care provider within 60 calendar days.

SECTION 7 Part D 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. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D* drug every time. We also use the term Drug List instead *of List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination**.

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

- Asking to cover a Part D drug that isn't on our plan's Drug List. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 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 made, you can appeal our decision.

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

Section 7.2 Asking for an exception

Legal Terms:

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

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

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

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 2 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.**
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.

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

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally **won't** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

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

Section 7.4 How to ask for a coverage decision, including an exception

Legal term:

A fast coverage decision is called an **expedited coverage determination**.

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get 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 2 requirements:**

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

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

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form or on our plan's form, which is available on our website www.villagecaremax.org. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

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

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

- We must give you our answer **within 72 hours** after we get your request.
    - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
    - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we get your request.
    - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review

organization. We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for,** we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 7.5 How to make a Level 1 appeal

Legal Terms:

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

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

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

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

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4.

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** 1-855-296-8800. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website

www.villagecaremax.org. Include your name, contact information, and information about your claim to help us process your request.

- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your

request has been sent to the independent review organization. Section 7.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

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

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

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

Section 7.6 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 isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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'll include **instructions on how to make a Level 2 appeal** with the independent review

organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.

- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to 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 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 independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

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

For standard appeals:

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

What if the independent review organization says no to your appeal?

If the independent 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 that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** talks 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're being discharged too soon

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-855-296-8800 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice ***doesn't* mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at 1-855-296-8800 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-855-296-8800 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance (HIICAP) and the phone number is 1-800-701-0501. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**

- **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
- **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-855-296-8800 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all the information 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 independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality

Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.

- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

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

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

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

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

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

When we decide it is time to stop covering any of the 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying for your care.*

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

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it *doesn't* mean you agree** with our plan's decision to stop care.

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-855-296-8800 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance (HIICAP) and the phone number is 1-800-701-0501. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go 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 10 Taking your appeal to Levels 3, 4 and 5

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

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

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

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

Section 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 want to continue the appeals process.

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

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**

    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **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 the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

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

Making complaints

SECTION 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 about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

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

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're being encouraged to leave our 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 our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Member Services at** 1-855-296-8800 (TTY users call 711) **is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **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
    - The deadline for making a complaint is 60 calendar days from the time you had the problem you want to complain about
- **Whether you call or write, you should call Member Services at** 1-855-296-8800 (TTY users call 711) **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'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 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 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 11.4 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 Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

You also have a right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- Phone: 1-866-712-7197
- Mail: New York State Department of Health
  Bureau of Managed Long Term Care
  Technical Assistance Center
  99 Washington Ave/ One Commerce Plaza 16th Fl
  Albany, NY 12210
- E-mail: mltctac@health.ny.gov

CHAPTER 10:
Ending membership in our plan

SECTION 1 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 decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

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

Section 2.1 You 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 can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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. If you receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- Call your State Medicaid Office at 800-541-2831(TTY 1-800-662-1220) to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.

- **Your membership will usually end on the first day of the month after we get your request to change your plan.** Your enrollment in your new plan will also begin on this day.

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

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
    - Another Medicare health plan, with or without drug coverage.
    - Original Medicare *with* a separate Medicare drug plan
    - Original Medicare *without* a separate Medicare drug plan.
    - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

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

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:

  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 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 our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. 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.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,

- Original Medicare *with* a separate Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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 get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan.

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 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-855-296-8800 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from VillageCareMAX Medicare Total Advantage Plan when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan.

	• You'll automatically be disenrolled from VillageCareMAX Medicare Total Advantage Plan when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Call Member Services at 1-855-296-8800 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from VillageCareMAX Medicare Total Advantage Plan when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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 New York State Medicaid Program benefits, call New York State Medicaid at 800-541-2831 (TTY 1-800-662-1220). Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid Program coverage.

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

Until your membership ends, and your new Medicare and Medicaid coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

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

VillageCareMAX Medicare Total Advantage Plan must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you're 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. 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.
- If you move out of our service area
- If you're away from our service area for more than 6 months.
    - If you move or take a long trip, call Member Services at 1-855-296-8800 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Member Services at 1-855-296-8800 (TTY users call 711).

Section 5.1 We <u>can't</u> ask you to leave our plan for any health-related reason

VillageCareMAX Medicare Total Advantage Plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at 1-855-296-8800 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't 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

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

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

Benefit Period –The way that our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that's 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.

Care Plan – A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and LTSS.

Care Team – A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

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

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

Complaint — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is 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 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that's 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're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Health Risk Assessment – A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. (**Note:** Because our members also get help 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's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare

prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan isn't 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're 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**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded 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 plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're 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 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're 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.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include

programs for health monitoring, and counseling and education to help you take care of your own health.

Primary Care Physician (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 based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that's designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where

you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

Chapter 13/Appendix: VillageCareMAX Medicaid Advantage Plus (MAP) Member Handbook

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WELCOME TO VillageCareMAX Medicare Total Advantage Plan MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to VillageCareMAX Medicare Total Advantage Plan Medicaid Advantage Plus (MAP) Program. 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.

This handbook tells you about the added benefits VillageCareMAX Medicare Total Advantage Plan covers since you are enrolled in the VillageCareMAX Medicare Total Advantage Plan MAP Program. It also tells you how to request a service, file a complaint or disenroll from VillageCareMAX Medicare Total Advantage Plan MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the VillageCareMAX Medicare Total Advantage Plan Medicare Evidence of Coverage. Keep this 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.

Section I- HELP FROM MEMBER SERVICES

You can call us anytime, 24 hours a day, seven days a week, at the Member Services numbers below.

There is someone to help you at Member Services:
8AM TO 8PM, 7 days a week
Call 1-855-296-8800 (TTY users call 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 1-855-296-8800 (TTY users call 711), during the hours of 8:00 am to 8:00 pm, 7 days a week.

Section II -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 or older,
2) Reside in the Plan's service area which is Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Nassau, Richmond (Staten Island), and Westchester
3) Have Medicaid,
4) Have evidence of Medicare Part A & B coverage,

5) Must enroll in VillageCareMAX Medicare Total Advantage Plan Medicare Advantage Dual Special Needs Plan
6) Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety or you are permanently placed in a nursing home,
7) Need at least one CBLTSS for more than 120 days and the following:

- individuals with a diagnosis by a physician of Dementia or Alzheimer's and needs help with at least supervision with more than one activity of daily living (ADL); or
- individuals who are assessed as needing at least limited assistance with physical maneuvering with more than two ADLs.

CBLTSS includes services provided in the home or community setting (any place of residence, either permanent or temporary, other than a hospital, skilled nursing home, or health related facility) as included in the MAP plan benefit package and provided by the MAP plan when medically necessary. CBLTSS services includes Private Duty Nursing, Skilled Nursing, Home Health Services, Personal Care Services*, Consumer Directed Personal Assistance Services, and Adult Day Health Care.

* Level 2 requires physical assistance with activities of daily living. Services such as housekeeping and shopping do not meet the need for level 2 services. More information is available in Title 18 - 505.14.

Note: Individuals enrolled in the MLTC program as of August 2025 will be granted MLTC Plan Legacy status and be assessed under previous criteria as long as they remain continuously enrolled. These MLTC Plan Legacy individuals will not be required to meet the Minimum Needs Requirements at reassessment.

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.

The coverage explained in this handbook 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 Program (NYIAP)- Initial Assessment Process

The NYIAP will conduct an initial assessment for individuals who have expressed an interest in enrolling in a Managed Long Term Care plan. 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 MLTC 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 NYIAP 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 NYIAP will complete a clinical appointment and PO a few days later.

Annually, you, as a MLTC enrollee will then be reassessed by VillageCareMAX Medicare Total Advantage Plan, to ensure your needs still meet the MLTC Program Eligibility requirements.

VillageCareMAX Medicare Total Advantage Plan will use the CHA and PO outcomes to see what kind of help you need and create your initial plan of care. If your plan of care proposes PCS and/or CDPAS for more than twelve (12) hours per day on average, a separate review by the NYIAP 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 necessary medical documentation. If more information is needed, someone on the panel may ask to examine you and/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 NYIAP has completed the initial assessment steps and determined that you are eligible for MLTC, you can then choose which MLTC 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 1-855-296-8800. 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 Program (NYIAP). You may also call NYIAP 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 Plan 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 the New York State Medicaid Program and Medicare for approval. They are responsible for processing all enrollments.

- If the New York State Medicaid Program receives the completed enrollment package by the 25th 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 25, your enrollment would take place on February 1.)
- If Medicaid receives the enrollment package after the 25th 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 26, 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 New York State Medicaid Program and Medicare as appropriate, and will mail you a confirmation of cancellation

letter. If your enrollment request was already sent to Medicare and New York State Medicaid Program, the Plan must receive approval or notification from both Medicare and New York State Medicaid Program to cancel your enrollment. You can cancel your enrollment in the Medicaid Advantage Plus (MAP) part of the plan before noon of the 25th 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 both Medicare and New York State Medicaid Program.

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, New York Medicaid Choice, the entity that processes the Plan enrollment denial 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 fourteen (14) days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact VillageCareMAX Medicare Total Advantage Plan's Member Services at **1-855-296-8800. TTY users should call 711. Our hours are 8:00 am to 8:00 pm, 7 days a week.**

Behavioral Health Appointment Standards

Use the following list as the **appointment standards for our limits on how long you may have to wait after your request for a behavioral health appointment**:

- Initial appointment with an outpatient facility or clinic: 10 business days
- Initial appointment with a behavioral health care professional who is not employed by or contracted with an outpatient facility or clinic: 10 business days
- Follow-up visit after mental health/substance abuse emergency room (ER) or inpatient visit: 5 business days
- Non-urgent mental health or substance abuse visit: 5 business days

If you are unable to schedule a behavioral health appointment within the appointment wait times listed above, you, or your designee, may submit an access complaint to VillageCareMAX Medicare Total Advantage Plan by telephone, 1-855-296-8800 (TTY: 711) and in writing to VillageCareMAX Medicare Total Advantage Plan 112 Charles Street New York, New York 10014 to resolve this issue.

If we are unable to locate a plan participating provider that can treat your behavioral health condition, you can receive a referral to a qualified out-of-network provider who can.

Behavioral Health Access Complaint

If you are unable to schedule a behavioral health appointment and if you submit a behavioral health access complaint, VillageCareMAX Medicare Total Advantage Plan must provide you with the name and contact information of a provider that can treat your behavioral health condition. VillageCareMAX Medicare Total Advantage Plan must provide this information within three (3) business days after receiving your complaint.

Section III - 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 Medicare Evidence of Coverage. Chapter 3 of the VillageCareMAX Medicare Total Advantage Plan Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or urgent care situation. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Chapter 4 of VillageCareMAX Medicare Total Advantage Plan Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined VillageCareMAX Medicare Total Advantage Plan, and you have Medicaid, VillageCareMAX Medicare Total Advantage Plan will pay these amounts on your behalf. 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 Chapter 1 of the VillageCareMAX Medicare Total Advantage Plan Medicare 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 1-855-296-8800 (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. 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 <u>not</u> 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 you must get authorization from the Plan. Your doctor will need to provide signed written orders to the Adult Day Health Care provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Audiology/Hearing Aids not covered by Medicare Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.	You must get audiology/hearing aids from the VillageCareMAX Provider Network. Prior authorization may be required.

Service	Coverage Rules
Consumer Directed Personal Assistance This is a self-directed program where a member or a person acting on a member's behalf, known as a designated representative, directs and manages the member's personal care services, home health aide services or skilled nursing tasks. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping. This is provided by an aide chosen and directed by the member or a designated representative.	All CDPAP recipients are required to work with PPL as their Fiscal Intermediary. 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
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 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.

Service	Coverage Rules
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 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.
Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit Services include mental health care services that require a hospital stay. Medicaid covers the deductible and cost of the days in excess of the Medicare 190-day lifetime limit. There is no limit to the number of days covered by the plan each hospital stay. You are covered for up to 365 days per year (366 in a leap year) with no deductible or copayment.	You must get inpatient mental health services from the VillageCareMAX Provider Network. 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.
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 be covered by Medicare. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.

Service	Coverage Rules
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. Nursing Home Care is covered for individuals who are considered to be permanently placed in a nursing home, provided you are eligible for institutional Medicaid coverage.	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. Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network provider and get authorization from the Plan.
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. Under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition. 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.	You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network, and you must get authorization from the Plan.

Service	Coverage Rules
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.
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 will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. 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. You can get services from or outside of the VillageCareMAX Provider Network and get authorization from the Plan.

Service	Coverage Rules
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. *Consumer Directed Personal Assistance Program* Statewide Fiscal Intermediary As of April 1, 2025, members must contact Public Partnerships Ltd. (PPL) to register Public Partnerships Ltd. (PPL) Support Center: 1-833-247-5346 or TTY: 1-833-204-9042. Website: pplfirst.com/cdpap	You must get personal care from the VillageCareMAX Provider Network, and you must get authorization from the Plan. Your doctor will need to provide signed written orders to the agency providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed. All CDPAP recipients are required to work with PPL as their Fiscal Intermediary. Prior authorization is required from VillageCareMAX.
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 you must get authorization from the Plan.
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.

Service	Coverage Rules
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.
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 you must get authorization from the Plan.
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 you must get authorization from the Plan.

Health Related Social Needs (HRSN) Screening and Services

As of **January 1, 2025**, you can receive screening and referral to existing local, state and federal services through regional Social Care Networks (SCNs). If you are eligible, these local groups can connect you to services in your community that help with housing, transportation, education, employment, and care management at no cost to you.

- After screening through this SCN, you and any interested member(s) in your household can meet with a Social Care Navigator who can confirm eligibility for services that can help with individual health and well-being. They may ask you or members in your household for supporting documentation to determine where extra support may be needed.

- If you or any member(s) in your household qualify for services, the Social Care Navigator can work with you to get the support needed. You may qualify for more than one service, depending on individual eligibility. These services include:

    - Housing and utilities support:
        - Installing home modifications like ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, and non-skid surfaces to make your home accessible and safe.
        - Mold, pest remediation, and asthma remediation services.
        - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
        - Providing small refrigeration units needed for medical treatment.
        - Helping you find and apply for safe and stable housing in the community which may include assistance with rent and utilities.

        NOTE: Some housing services may be covered by your plan. Therefore, some housing services will require coordination between the Social Care Navigator and your health plan's care manager.

    - Transportation services:
        - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.

    - Care management services:
        - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
        - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

Getting in Contact with an SCN in your area:

1. You may call the health plan's member services 1-855-296-8800 (TTY:711) and we will connect you to a SCN in your area.

2. You may call the SCN within your county and request a screening or more information. See the SCN contact information in the chart below.

3. You may also visit their website to begin a self-screening.

Once connected with the SCN, a Social Care Navigator will confirm your eligibility by asking questions, requesting supporting documentation (if necessary), tell you more about eligible services, and help you get connected to them.

SCN	Counties	Phone number
Health Equity Alliance of Long Island	Nassau, Suffolk	516-505-4434
	https://healiny.org/	
Hudson Valley Care Coalition, Inc.	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	800-768-5080
	https://hudsonvalleycare.org/services/hudson-valleys-social-care-network/	
Public Health Solutions	Manhattan, Queens, Brooklyn	888-755-5045
	https://www.wholeyou.nyc/	
Staten Island Performing Provider System	Richmond	917-830-1140
	https://statenislandpps.org/social-care-network/	
Somos Healthcare Providers, Inc.	Bronx	833-SOMOSNY (833-766-6769)
	https://www.somoscommunitycare.org/social-care-network/	

Covered Behavioral Health (Mental Health and Addiction) Services

Adult Outpatient Mental Health Care

- **Continuing Day Treatment (CDT):** Provides seriously mentally ill adults with the skills and supports necessary to remain in the community and be more independent. You can attend several days per week with visits lasting more than an hour.
- **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.

Adult Outpatient Rehabilitative Mental Health Care

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community.
- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

Adult Outpatient Rehabilitative Mental Health And Addiction Services For Members Who Meet Clinical Requirements. These are also known as CORE.

Community Oriented Recovery and Empowerment (CORE) Services: Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer someone, or self-refer, to CORE Services.

- **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources.
- **Community Psychiatric Supports and Treatment (CPST):** This service helps you manage symptoms through counseling and clinical treatment.
- **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.
- **Empowerment Services – Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:
  - live with health challenges and be independent
  - help you make decisions about your own recovery, **and**
  - find natural supports and resources.

Adult Mental Health Crisis Services

- **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.
- **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.

- **Crisis Residential Programs:** A short term residence that provides 24 hours per day services for up to 28 days, for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support your return to your community.

Adult Outpatient Addiction Services

Opioid Treatment Centers (OTP) are Office of Addiction Services and Supports certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

Adult Residential Addiction Services
Residential Services are for people who are in need of 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.

Adult Inpatient Addiction Rehabilitation Services

State Operated Addiction Treatment Center's (ATC) provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.

Inpatient Addiction Rehabilitation programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24- hour, 7-day a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.

Inpatient Medically Supervised Detox programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.

Telehealth
You can receive some services through telehealth when appropriate. You may receive telehealth services through eConsults or electronic consultations which are communications between your doctor and specialists. It is your choice if you receive services in person or through telehealth. If you have additional questions on telehealth, please contact your Care Manager.

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. 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 after the emergency incident 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 Medicare Total Advantage Plan 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 existing person-centered service plan for a transitional period of up to ninety (90) days from enrollment or until a new person-centered service plan is agreed upon between the new Enrollee and VillageCareMAX Medicare Total Advantage Plan, whichever is first.

Additionally, new enrollees in VillageCareMAX Medicare Total Advantage Plan may continue an ongoing course of treatment for a transitional period of up to ninety (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
Money Follows the Person (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 and
- Have health needs that can be met through services in the 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, and/or
- 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.

Section IV- 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 1-855-296-8800 (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.

The services listed below are services available through regular Medicaid:

Certain Mental Health Services, including:

- Health Home (HH) and Health Home Plus (HH+) Care Management services
- Rehabilitation Services Provided to Residents of Office of Mental Health (OMH) Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment
- Office of Addiction Services and Supports (OASAS) Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)
- OMH Residential Treatment Facility (RTF)

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:

- Directly Observed Therapy for TB (Tuberculosis)
- 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).

Non-Emergency Transportation

- Covered under regular Medicaid and arranged by the Statewide Transportation Broker, with the exception of Social Adult Daycare (SADC) programs. SADC providers are responsible for providing transportation to and from their programs for members.

SERVICES NOT COVERED BY VillageCareMAX Medicare Total Advantage Plan OR MEDICAID

- You must pay for services that are not covered by VillageCareMAX Medicare Total Advantage Plan 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 from a provider that is not part of the plan outside of a medical emergency (unless VillageCareMAX Medicare Total Advantage Plan authorizes you to see that provider)

If you have any questions, call Member Services at 1-855-296-8800 (TTY:711).

Section V- SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

You have Medicare and also get assistance from Medicaid. Information in this section covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will use one process for both your Medicare and/or Medicaid benefits. 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 237 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

You, your doctor, or designated representative may call Member Services at 1-855-296-8800 (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 120 Broadway, Suite 2840,
New York, NY 10271

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 before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved **before** you get them:

Service	Coverage Rules
Adult Day Health Care Provides care and services in a residential health care facility or approved extension site. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as 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. 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. Prior authorization is required from VillageCareMAX
Audiology/Hearing Aids not covered by Medicare Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.	You must get audiology/hearing aids from the VillageCareMAX Provider Network. Prior authorization may be required from VillageCareMAX.
Consumer Directed Personal Assistance This is a self-directed program where a member or a person acting on a member's behalf, known as a designated representative, directs and manages the member's personal care services, home health aide services or skilled nursing tasks. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping. This is provided by an aide chosen and directed by the member or a designated representative.	You must coordinate your consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX. Prior authorization is required from VillageCareMAX.

Service	Coverage Rules
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 may be required from VillageCareMAX.
Durable Medical Equipment (DME) not covered by Medicare 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. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed. Prior authorization is required from VillageCareMAX for certain items.
Home-Delivered Meals and/or Meals in a Group Setting 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 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.

Service	Coverage Rules
Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit Services include mental health care services that require a hospital stay. Medicaid covers the deductible and cost of the days in excess of the Medicare 190-day lifetime limit. There is no limit to the number of days covered by the plan each hospital stay. You are covered for up to 365 days per year (366 in a leap year) with no deductible or copayment.	You must get inpatient mental health services from the VillageCareMAX Provider Network. 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.
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 be covered by Medicare. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed. Prior authorization is required from VillageCareMAX.
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 VillageCareMAX two days in advance to schedule transportation. Prior authorization is required from VillageCareMAX.

Service	Coverage Rules
Nursing Home Care not covered by Medicare Medicaid-covered care provided in a Skilled Nursing Facility	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. Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network provider. Prior authorization is required from VillageCareMAX.
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. Prior authorization is required from VillageCareMAX.
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 from VillageCareMAX.
Outpatient Mental Health & Substance Abuse Services to treat mental health and substance abuse conditions in an outpatient setting.	You must get outpatient mental health & substance abuse services from the VillageCareMAX Provider Network. You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period. Prior authorization is required for certain services.

Service	Coverage Rules
Personal Care Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks.	You must get personal care from the VillageCareMAX Provider Network. Your doctor will need to provide signed written orders to the agency providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed. Prior authorization is required from VillageCareMAX.
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. Prior authorization is required from VillageCareMAX.
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 will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. 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. You can get services from or outside of the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.

Service	Coverage Rules
Podiatry services not covered by Medicare Podiatry means services by a podiatrist, which must include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.	You can get podiatry services from or outside of the VillageCareMAX Provider Network.
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. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed. Prior authorization is required from VillageCareMAX.

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. 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. Prior authorization is required from VillageCareMAX.
Social and Environmental Supports 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. Prior authorization is required from VillageCareMAX.
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. Prior authorization is required from VillageCareMAX.
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. Prior authorization is required from VillageCareMAX.

Service	Coverage Rules
Veteran's Home Services If you are a veteran, spouse of a veteran, or Gold Star parent in need of long term nursing home services, you may access Veteran's Home Services.	If VillageCareMAX does not have an accessible in-network veteran's home, the plan will authorize out-of-network services until member is transferred to another plan with an in-network veteran's home. Prior authorization is required from VillageCareMAX.

Concurrent Review
You can also ask VillageCareMAX 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 health plan has a review team to be sure you get the services you qualify for. Doctors and nurses are on the review team. Their job is to be sure the treatment or services you asked for are medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

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

After we get your request, we will review it under either a **standard** or a **fast-track** process. You or your provider can ask for a fast-track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast-track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast-track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your requested amount. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process

Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item, treatment, or service unless we have agreed to use the fast-track deadlines.

- A **standard review** for a prior authorization request means we will give you an answer within three (3) workdays of when we have all the information we need, but no later than **seven (7) calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 workday of when we have all the information we need but will give you an answer no later than seven (7) calendar days after we get your request.
- **We can take up to fourteen (14) more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than fourteen (14) days from the day we asked for more information.
- If you believe we should **not** take extra days, you can file a **fast complaint**. When you file a **fast complaint**, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 4: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within seven (7) calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **If our answer is yes to part or all of what you asked for**, we will authorize the service, or treatment, 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 an Appeal Decision Notice that explains why we said no. More information about how to appeal this decision can be found in Section 2: Level 1 Appeals.

Fast Track Process

If your health requires it, ask us to give you a **fast service authorization**.

- A **fast review** of a prior authorization request means we will give you an answer within 1 workday of when we have all the information, we need but no later than 72 hours from when you made your request to us.
- We can take **up to fourteen (14) more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest.
- We will make a decision as quickly as we can when we receive the necessary information, but no later than fourteen (14) days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a fast complaint**. For more information about the process for making complaints, including fast complaints, see Section 4: What To Do If You Have A Complaint About Our Plan, below, for more information. We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal. To get a **fast service authorization**, you must meet two requirements:
    1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a **fast service authorization** if your request is about payment for medical care, you already got.)
    2. Using the standard deadlines could cause serious harm to your life or health or hurt your ability to function.

If your provider tells us that your health requires a fast service authorization, we will automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider's support, we will decide whether your health requires that we give you a **fast service authorization**.

If we decide that your medical condition does not meet the requirements for a **fast service authorization**, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your provider asks for the **fast service authorization**, we will automatically give a **fast service authorization**.
- The letter will also tell how you can file a **fast complaint** about our decision to give you a standard service authorization instead of the fast service authorization you asked for.

(For more information about the process for making complaints, including fast complaints, see Section 4: What To Do If You Have A Complaint About Our Plan later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service
authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

If our answer is no to part or all of what you asked for, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If you do not hear from us within these timeframes, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

<u>If we are changing a service you are already getting</u>

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are reviewing care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF)** services is ending. For more information about these rights, refer to Chapter 9 of the VillageCareMAX Medicare Total Advantage Evidence of Coverage.

What To Do If You Want To Appeal A Decision About Your Care
If we say no to your request for coverage for a medical item or service, you can decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).

- VillageCareMAX Medicare Total Advantage Plan can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-855-296-8800 (TTY: 711) get more information on your rights and the options available to you.

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

Section 2: Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

You can file a Level 1 Appeal:

If you are unhappy with a decision VillageCareMAX Medicare Total Advantage Plan makes, you can file an appeal. This is called a Level 1 appeal. Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 1 appeal on any decision VillageCareMAX Medicare Total Advantage Plan makes.

Aid to continue while appealing a decision about your care

If VillageCareMAX Medicare Total Advantage Plan reduces, suspends, or stops a service you are getting now, you may be able to continue the service while you wait for a Level 1 appeal determination.

You must ask for a Level 1 appeal:

- **Within ten (10) days from being told that your care is changing, or**
- **By the date the change in service is scheduled to occur, whichever is later.**

If your Level 1 appeal results in another denial, you will not have to pay for the cost of any continued benefits that you receive.

If you are unhappy with your Level 1 appeal decision, you can appeal again. This is called a Level 2 appeal. Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 2 appeal on any decision VillageCareMAX Medicare Total Advantage Plan makes.

Aid to continue while waiting for a Fair Hearing decision

You may be able to continue your services while you wait for a Fair Hearing determination. Continuation of benefits is only available if VillageCareMAX Medicare Total Advantage Plan reduces, suspends, or stops a service, and the service is covered by Medicaid.

You must ask for a Fair Hearing:

- **Within ten (10) days from the date of the Appeal Decision letter, or**
- **By the date the change in services is scheduled to occur, whichever is later.**

If your Fair Hearing results in another denial, you may have to pay for the cost of any continued benefits that you received.

If you are unhappy with the Level 2 appeal decision for a service covered by Medicare, you may have other appeal rights options. For more information about additional appeals rights options, see Chapter 9 of your Medicare Advantage D-SNP EOC or call Member Services.

Section 3: 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 (the 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 Plan or the State make the decision. These reviewers are qualified people approved by the 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 Appeal Decision Notice:

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 **four (4) months** after you get the Plan's **Appeal Decision Notice** 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 four (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 1-855-296-8800 (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 1-855-296-8800 (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 workdays) 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 4: What To Do If You Have A Complaint About Our Plan

Information in this section applies to **all** of your Medicare and Medicaid benefits, except Medicare Part D. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our Plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at 1-855-296-8800 (TTY: 711) or write to Member Services. The formal name for making a complaint is filing a grievance.

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- **Usually, calling** Member Services **is the first step.** If there is anything else you need to do, Member Services will let you know. 1-855-296-8800 (TTY: 711) 8AM to 8 PM, 7 days a week.

- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us**. If you put your complaint in writing, we will respond to your complaint in writing.

- Tell us about your complaint by phone or in writing. If you choose to send in writing, please use the address listed in Chapter 2, Section 2 called: *How to contact us when you are making a complaint about your medical care*. The Grievances team will investigate your complaint and reach out to you with any questions. You will be notified once the review has been completed, and given the outcome of the investigation.

- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- We answer complaints within thirty (30) calendar days.
- If you are making a complaint because we denied your request for a fast service authorization or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you an answer within 24 hours.
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to fourteen (14) more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:
    - If you asked us to give you a fast service authorization or a fast appeal and we said, we will not.
    - If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
    - When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

If you disagree with a decision we made about your complaint about your Medicaid benefits, you or someone you trust can file a complaint appeal with the Plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide you have sixty (60) workdays after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you.
- You must make the complaint appeal in writing.
    - If you make an appeal by phone, you must follow it up in writing.
    - After your call, we will send you a form that summarizes your phone appeal.
    - If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:
After we get your complaint appeal, we will send you a letter within fifteen (15) workdays. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact this person.
- If we need more information.

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within thirty (30) workdays from the time we have all information needed. If a delay would risk your health, you will get our decision in two (2) workdays of when we have all the information. We will give you the reasons for our decision and our clinical rationale if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.

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 call ICAN to get free, independent advice about your
coverage, complaint, and appeal options. They can help you manage the appeal process.

ICAN can also provide support before you enroll in a MLTC plan like VillageCareMAX Medicare Total Advantage Plan. This support includes unbiased health plan choice counseling and general plan related information.

Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
633 Third Ave, 10th Floor, New York, New York 10017
Web: www.icannys.org | Email: ican@cssny.org

Phone: 1-844-614-8800 (TTY Relay Service: 711)
8:00 am – 6:00 pm, Monday –Friday

Through the ICAN website, you can chat with a live counselor or submit a request for one to call you back.

Section VI- DISENROLLMENT FROM VillageCareMAX Medicare Total Advantage Plan MAP PROGRAM

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

- High utilization of covered medical services, an existing condition or a change in the Enrollee's health, or

- diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

You Can Choose to Voluntary Disenroll

You can ask to leave the VillageCareMAX Medicare Total Advantage Plan, MAP PROGRAM at any time for any reason.

To request disenrollment, call 1-855-296-8800 (TTY:711). It could take up to six (6) 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 or Home and Community Based Waiver program, in order to continue to receive CBLTSS services.

You Will Have to Leave VillageCareMAX Medicare Total Advantage Plan, MAP Program if:

- You no longer are enrolled in VillageCareMAX Medicare Total Advantage Plan for your Medicare coverage,
- You no longer are Medicaid eligible,
- You need nursing home care, but are not eligible for institutional Medicaid,
- You are out of the Plan’s service area for more than thirty (30) consecutive days,
- You permanently move out of VillageCareMAX Medicare Total Advantage Plan service area,

- You are a MLTC Legacy Status Enrollee and you no longer eligible for nursing home level of care as determined using the CHA, unless the termination of the services provided by the Plan could reasonably be expected to result in you being eligible for nursing home level of care within the succeeding six-month period,
- At the point of any reassessment while living in the community, you are determined to no longer meet the Minimum Needs ADL requirement,
- You have not received one of the CBLTSS services such as adult day health care, private duty nursing, home health aide services, CDPAS, or services in the home including personal care services (Level 2), nursing services or therapies. Please note that Social Adult Day Care services alone do not qualify you for continued enrollment,
- You join a Home and Community Based Services waiver program, or become a resident of an Office for People with Developmental Disabilities residential program,
- You become a resident of an OMH or OASAS residential program (that is not a MAP plan covered benefit) for forty-five (45) consecutive days or longer, or
- You refused to complete a required reassessment.

We May Ask You to Leave the VillageCareMAX Medicare Total Advantage Plan, MAP Program 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.
- You knowingly provide fraudulent information on an enrollment form, or you permit abuse of an enrollment card in the MAP Program;
- You fail to complete and submit any necessary consent or release; or
- You fail to pay or make arrangements to pay the amount of money, as determined by the Local District of Social Services (LDSS), owed to the Plan as spenddown/surplus within thirty (30) days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, VillageCareMAX Medicare Total Advantage Plan will obtain the approval of New York Medicaid Choice (NYMC), or an entity designated by the State to notify you of the intent to disenroll. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you continue to need CBLTSS, you will be required to choose another plan or you will be auto assigned to

another plan to provide you with coverage for needed services. Upon re-enrollment in the MAP Program, you may need to be assessed by NYIAP again.

Section VII- CULTURAL AND LINGUISTIC COMPETENCY

VillageCareMAX Medicare Total Advantage Plan 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 enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Section VIII- MEMBER RIGHTS AND RESPONSIBILITIES

VillageCareMAX Medicare Total Advantage Plan 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 gender, 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; and the right to request a fair hearing through the Office of Administrative Hearings 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

- You have the responsibility to receive covered services through VillageCareMAX Medicare Total Advantage Plan.

- You have the responsibility to use VillageCareMAX Medicare Total Advantage Plan network providers for these covered services, to the extent network providers are available.
- You have the responsibility to obtain prior authorization for covered services, except for pre-approved covered services or in emergencies.
- You have the responsibility to see by your physician if a change in your health status occurs.
- You have the responsibility to share complete and accurate health information with your health care providers.
- You have the responsibility to inform VillageCareMAX Medicare Total Advantage Plan staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- You have the responsibility to follow the plan of care recommended by the VillageCareMAX Medicare Total Advantage Plan staff (with your input.)
- You have the responsibility to cooperate with and be respectful with the VillageCareMAX Medicare Total Advantage Plan staff and not discriminate against VillageCareMAX Medicare Total Advantage Plan staff because of race, color, national origin, religion, gender, age, mental or physical ability, sexual orientation, or marital status.
- You have the responsibility to notify VillageCareMAX Medicare Total Advantage Plan within two business days of receiving non-covered or non-pre-approved services.
- You have the responsibility to notify your VillageCareMAX Medicare Total Advantage Plan health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- You have the responsibility to inform VillageCareMAX Medicare Total Advantage Plan before permanently moving out of the service area, or of any lengthy absence from the service area.
- You have the responsibility for the consequences of your actions if you refuse treatment or do not follow the instructions of your caregiver.

- You have the responsibility to meet 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 Medicare Total Advantage Plan.
    - Specific clinical review criteria relating to a particular health condition and other information that VillageCareMAX Medicare Total Advantage Plan 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 Medicare Total Advantage Plan certified financial statement; and policies and procedures used by VillageCareMAX Medicare Total Advantage Plan to determine eligibility of a provider.
- You can receive information in another language or another format like large print, or braille by calling Member Services at 1-855-296-8800 (TTY:711).

Electronic Notice Option

VillageCareMAX Medicare Total Advantage Plan and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices by web portal. The web portal option works by sending you an email notification with a link. The enrollee or designee must click on the link to log into the web portal to see the notices. Before you can use this option, you must have an email address, and a web browser with access to the internet.

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone, email, online, fax, or mail:

Phone 1-855-296-8800 (TTY:711)
Email..... vcmaxmembers@villagecare.org
Online ..... http://www.mydocuments.villagecaremax.org
Fax 1-212-337-5711
Mail ..... 120 Broadway, Suite 2840, New York, NY 10271

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

VillageCareMAX Medicare Total Advantage Plan will let you know by mail that you have asked to get notices electronically.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-800-469-6292; TTY/TDD: 711.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-800-469-6292; TTY/TDD: 711	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-800-469-6292; TTY/TDD: 711。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-800-469-6292; TTY/TDD: 711	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-800-469- 6292; TTY/TDD: 711번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-800-469-6292; TTY/TDD: 711	Russian

ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-800-469-6292; TTY/TDD: 711	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-800-469-6292; TTY/TDD: 711	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-800-469-6292; TTY/TDD: 711	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט711 :TTY/TDD ;1-800-469-6292	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-800-469-6292; TTY/TDD: 711	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-800-469-6292; TTY/TDD: 711	Tagalog
মেনা◌োযাগ নামূ◌েলয্ ভাষা সহায়তা পিরেষবা এবং অনয্◌ানয্ সাহাযয্ আপনার জনয্ উপল□। 1-800-469-6292; TTY/TDD: 711-এ ◌েফান করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-800-469-6292; TTY/TDD: 711	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-800-469-6292; TTY/TDD: 711	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں711 :TTY/TDD ;1-800-469-6292۔	Urdu

Member Services – Contact Information	
Call	1-855-296-8800 Calls to this number are free. 7 days a week, 8 am to 8 pm. Member Services 1-855-296-8800 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 am to 8 pm.
Fax	1-212-337-5711
Write	VillageCareMAX Attn: Member Services 120 Broadway, Suite 2480 New York, NY 10271
Website	www.villagecaremax.org

New York State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

New York State Health Insurance Assistance Program – Contact Information	
Call	1-800-701-0501
Website	https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs

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