

# Summary of Benefits



## Medicare Advantage and Part D

**Plan year:** January 1 – December 31, 2023

### Arizona

Pima county

**Amerivantage Lung Care Plus (HMO C-SNP)**

**Amerivantage Heart Care Plus (HMO C-SNP)**

23AZH1423M1

## Thank you for your interest in our Medicare Advantage plans

Amerivantage Lung Care Plus (HMO C-SNP) and Amerivantage Heart Care Plus (HMO C-SNP) are a special type of Medicare Advantage plan called a Chronic Condition Special Needs Plan (C-SNP). These C-SNPs are designed for people living with a chronic lung or cardiovascular disorder, or chronic heart failure. These plans offer extra benefits and services to support you.

# Amerivantage Lung Care Plus (HMO C-SNP) and Amerivantage Heart Care Plus (HMO C-SNP)

## Amerivantage Lung Care Plus (HMO C-SNP) and Amerivantage Heart Care Plus (HMO C-SNP)

Our service area includes this county in AZ: Pima

### Do you have questions?



- You can learn more on our website, <https://shop.amerigroup.com/medicare>.



- Or call us toll-free **1-877-211-6614** (TTY: **711**).
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

The *Summary of Benefits* does not include every service, limit, or exclusion, but the *Evidence of Coverage* does. Just give us a call to request a copy.

Amerivantage Lung Care Plus (HMO C-SNP) and Amerivantage Heart Care Plus (HMO C-SNP) are Medicare Advantage plans. They include hospital, medical, and prescription drug benefits. To join one of these plans, the following must apply to you:

- You're entitled to Medicare Part A.
- You're enrolled in Medicare Part B.
- You're diagnosed with a chronic lung disorder, cardiovascular disorder, and/or chronic heart failure.
- You live in our service area.

You need to visit doctors and facilities in this plan's network. This is very important. If you go outside the network, the services may not be covered.

## Medicare coverage that goes beyond Original Medicare

- These plans cover everything Original Medicare covers — Part A (hospital services) and Part B (medical services) — plus more.
- These plans cover Medicare Part D drugs and Part B drugs (such as chemotherapy and certain drugs your doctor administers).

## These are Health Maintenance Organization Special Needs Plans (HMO SNP). That means:

- You must choose a primary care physician (PCP) in the plan's network of doctors for covered services. Your PCP provides most of your medical care, including routine care and hospitalizations. They can help you save time and money by directing you to specialists when needed.
- Before you visit a specialist, we recommend you talk to your PCP first. They know your health history and can help you find the right care.

## Is your PCP in our plan's network of doctors?



If you need to change your primary care physician (PCP), give us a call and we'll help. Doctors can join or leave the network at any time, so check if they're in-network with our Find a Doctor tool online. Just follow the steps below.

### How to find a doctor/PCP in our plan:



- Go to <https://shop.amerigroup.com/medicare>
  1. Select **Useful Tools** and choose **Find a Doctor**.
  2. Enter your ZIP code, county and the date you want your coverage to begin.
  3. Fill in the details (city, doctor's name, distance, etc.).
  4. Be sure to check that the doctor is listed as "In-Network" for this plan.
- Or you can ask us for the *Provider Directory*. The phone number is on page 2.

# Know your drug plan

## Prescription drugs are an important part of health and wellness

Amerivantage Lung Care Plus (HMO C-SNP) and Amerivantage Heart Care Plus (HMO C-SNP) cover medications that help you stay your healthiest, at the lowest cost possible. Check the plan's drug list, or *Formulary*, to see if your prescriptions are covered and at what price.

### How to check if your prescriptions (or an acceptable alternative) are covered and what they'll cost:



- Visit <https://shop.amerigroup.com/medicare>
  1. Select **Useful Tools** and choose **Find Your Covered Drugs**.
  2. Enter your ZIP code, county and beginning coverage date.
  3. Enter your drug name, dosage, quantity and refill frequency, and select **Add Drug** or **Next**.
  4. Select your pharmacy, and then select **View All Plans**.
  5. Choose **Plan Details** and then **Drug Cost** to view the drug's tier, specific cost, and coverage details.
- You can also call us at the number on page 2 for a copy of the *Formulary*.

## Find a pharmacy

Our plans include the majority of pharmacies in America, so you're likely to find one near you. If your pharmacy is not in this plan, you could end up paying more for your drugs.

To confirm your pharmacy is in the plan (or find a new one) see the *Pharmacy Directory* on our website at <https://shop.amerigroup.com/medicare>. Under **Useful Tools**, choose **Find a Pharmacy** to enter your location and search details. Preferred pharmacies are noted to the right of the pharmacy name. Or you can give us a call and we'll send you the directory.



## Save money through mail order or at preferred pharmacies

Use mail order or certain retail pharmacies (*preferred pharmacies*) to reduce costs. Using mail order or a preferred pharmacy can lower your copays and share of the cost, but the choice is yours.

Preferred pharmacies include Albertsons/Safeway, CVS Pharmacy, Costco, Giant Eagle Pharmacy, Harris Teeter Pharmacy, H-E-B PHARMACY, Kinney Drugs, Kroger, Publix, Roundy's, Walmart and about 5,000 independent pharmacies.

## Don't miss out on some Extra Help

Medicare offers Extra Help, a program with prescription drug assistance for people who qualify. Extra Help can cover prescription drug plan deductibles, premiums, copays, and coinsurance. Plus:

- The coverage gap stage will not apply to you.
- There are no late-enrollment penalties.



## To find out if you qualify for Extra Help, call:

- Our helpful representatives at **1-877-211-6614**.
- 1-800-MEDICARE (1-800-633-4227)** (TTY: **1-877-486-2048**), 24 hours a day/7 days a week.
- The Social Security Administration at **1-800-772-1213** (TTY: **1-800-325-0778**) Monday to Friday, 7 a.m. to 7 p.m.
- Your state Medicaid office.

## Optional supplemental dental and/or vision benefits



You can add an Optional Supplemental Benefits (OSB) package to the plan for an additional monthly premium. Optional Supplemental Benefits may not be available with every Medicare Advantage plan in this enrollment guide. See the *Optional Supplemental Dental and Vision Plans* section of the medical benefits chart for more details.





## Summary of 2023 medical benefits

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The next pages have more details about plan benefits, so you can choose the right plan for you.

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### How much is my premium (monthly payment)?

**\$0.00** per month

**\$0.00** per month

You must continue to pay your Medicare Part B premium.

### How much is my deductible?

This plan does not have a medical deductible.

This plan does not have a medical deductible.

This plan does not have a Part D deductible.

This plan does not have a Part D deductible.

### Is there a limit on how much I will pay for my covered medical services? (does not include Part D drugs)

**\$2,700.00** per year from doctors and facilities in our plan

**\$2,700.00** per year from doctors and facilities in our plan

Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Services you receive from doctors or facilities in our plan go toward your yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for covered Part A and Part B services for the rest of the year.

### Inpatient Hospital<sup>1</sup>

Facilities in our plan: Days 1-5: **\$200.00** per day, per admission / Days 6-90: **\$0.00** per day, per admission

Facilities in our plan: Days 1-5: **\$200.00** per day, per admission / Days 6-90: **\$0.00** per day, per admission

Our plan covers an unlimited number of days for an inpatient hospital stay. Per-day cost sharing applies to each new inpatient admission (Note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost sharing per day applies).



Amerivantage Lung Care Plus (HMO C-SNP)	Amerivantage Heart Care Plus (HMO C-SNP)
<b>Outpatient Hospital<sup>1</sup></b>	
Doctors and facilities in our plan: <b>\$175.00</b> copay	Doctors and facilities in our plan: <b>\$175.00</b> copay
What you will pay may depend on the service and where you are treated.	
<b>Ambulatory Surgical Center<sup>1</sup></b>	
Doctors and facilities in our plan: <b>\$75.00</b> copay	Doctors and facilities in our plan: <b>\$75.00</b> copay
<b>Doctor's Office Visits</b>	
<b>Primary care physician (PCP) visit:</b>	
PCPs in our plan: <b>\$0.00</b> copay	PCPs in our plan: <b>\$0.00</b> copay
<b>Specialist visit:<sup>1</sup></b>	
Doctors in our plan: <b>\$0.00 - \$35.00</b> copay	Doctors in our plan: <b>\$0.00 - \$35.00</b> copay
Your copay for services received through select locations is <b>\$0.00</b> .	
<b>Preventive Care Screenings and Annual Physical Exams</b>	
<b>Preventive care screenings:</b>	
Doctors in our plan: <b>\$0.00</b> copay	Doctors in our plan: <b>\$0.00</b> copay
<b>Annual physical exam:</b>	
Doctors in our plan: <b>\$0.00</b> copay	Doctors in our plan: <b>\$0.00</b> copay

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Preventive Care Screenings and Annual Physical Exams

#### Covered preventive care screenings:

- |  |   |
|--|---|
| <input type="checkbox"/> Abdominal aortic aneurysm screening   | <input type="checkbox"/> Hepatitis C Screening  |
| <input type="checkbox"/> Annual “wellness” visit   | <input type="checkbox"/> High Intensity Behavioral Counseling   |
| <input type="checkbox"/> Bone mass measurement   | <input type="checkbox"/> HIV screening  |
| <input type="checkbox"/> Breast cancer screening (mammogram)   | <input type="checkbox"/> Lung cancer screenings   |
| <input type="checkbox"/> Cardiovascular disease (behavioral therapy)   | <input type="checkbox"/> Medical nutrition therapy services   |
| <input type="checkbox"/> Cardiovascular screening  | <input type="checkbox"/> Obesity screenings and counseling  |
| <input type="checkbox"/> Cervical and vaginal cancer screening   | <input type="checkbox"/> Prostate cancer screenings (PSA)   |
| <input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | <input type="checkbox"/> Sexually transmitted infections screenings and counseling  |
| <input type="checkbox"/> Depression screening  | <input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) |
| <input type="checkbox"/> Diabetes prevention program   | <input type="checkbox"/> Vaccines, including flu, hepatitis B, pneumococcal, and COVID-19 shots                           |
| <input type="checkbox"/> Diabetes screenings and monitoring  | <input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time)  |

Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in our plan, **100%** of the cost of preventive care screenings and annual physical exams is covered.

<b>Amerivantage Lung Care Plus (HMO C-SNP)</b>	<b>Amerivantage Heart Care Plus (HMO C-SNP)</b>	
<b>Emergency Care</b>		
<p><b>\$120.00</b> copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p><b>Emergency and Urgent Care Worldwide Coverage</b></p> <p>This plan covers urgent care and emergency services when traveling outside of the United States for less than six months. This benefit is limited to <b>\$100,000.00</b> per year.</p>	<p><b>\$120.00</b> copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p><b>Emergency and Urgent Care Worldwide Coverage</b></p> <p>This plan covers urgent care and emergency services when traveling outside of the United States for less than six months. This benefit is limited to <b>\$100,000.00</b> per year.</p>	
<b>Urgently Needed Services</b>		
<p><b>\$15.00</b> copay</p>	<p><b>\$15.00</b> copay</p>	
<b>Diagnostic Services, Labs, and Imaging<sup>1</sup></b>		
	<b>Amerivantage Lung Care Plus (HMO C-SNP)</b>	<b>Amerivantage Heart Care Plus (HMO C-SNP)</b>
<p><b>Diagnostic Radiology Services</b> (such as MRIs, CT scans)</p> <p>CT, MRI, MRA, PET, and Nuclear studies:</p> <p>All other diagnostic tests:</p>	<p>\$150.00 copay</p> <p>\$0.00 copay</p>	<p>\$150.00 copay</p> <p>\$0.00 copay</p>
<p><b>Diagnostic Tests and Procedures</b></p> <p>Doctors' offices in our plan:</p> <p>Outpatient facilities in our plan:</p>	<p>\$0.00 copay</p> <p>\$0.00 copay</p>	<p>\$0.00 copay</p> <p>\$0.00 copay</p>

Amerivantage Lung Care Plus (HMO C-SNP)	Amerivantage Heart Care Plus (HMO C-SNP)	
<b>Diagnostic Services, Labs, and Imaging<sup>1</sup></b>		
<b>Lab Services</b>  Doctors' offices in our plan:  Outpatient facilities in our plan:	\$0.00 copay  \$0.00 copay	\$0.00 copay  \$0.00 copay
<b>Outpatient X-rays</b>  Doctors and facilities in our plan:  What you pay for these services may vary based on where you are treated.	\$15.00 copay	\$15.00 copay
<b>Therapeutic Radiology Services</b> (such as radiation treatment for cancer)  Doctors and facilities in our plan:	20% coinsurance	20% coinsurance

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Hearing Services

**Medicare-covered hearing services** (Exam to diagnose and treat hearing and balance issues):<sup>1</sup>

Doctors in our plan: **\$0.00** copay

Doctors in our plan: **\$0.00** copay

### Routine hearing services:<sup>1</sup>

This plan covers 1 routine hearing exam(s) and hearing aid fitting/evaluation(s) every year. **\$1,500.00** maximum plan benefit coverage amount applies to prescribed hearing aids covered by the plan every year.

Doctors in our plan: **\$0.00** copay for routine hearing exam(s). **\$0.00** copay for hearing aids up to the maximum plan benefit amount.

This plan covers 1 routine hearing exam(s) and hearing aid fitting/evaluation(s) every year. **\$1,500.00** maximum plan benefit coverage amount applies to prescribed hearing aids covered by the plan every year.

Doctors in our plan: **\$0.00** copay for routine hearing exam(s). **\$0.00** copay for hearing aids up to the maximum plan benefit amount.

### Dental Services

**Medicare-covered dental services** (this does not include services for care, treatment, filling, removal or replacement of teeth):<sup>1</sup>

Doctors and dentists in our plan: **\$0.00 - \$35.00** copay

Doctors and dentists in our plan: **\$0.00 - \$35.00** copay

### Preventive dental services:

This plan covers: 2 oral exam(s), 2 cleaning(s), 1 dental X-ray(s) every year.

Dentists in our plan: **\$0.00** copay

This plan covers: 2 oral exam(s), 2 cleaning(s), 1 dental X-ray(s) every year.

Dentists in our plan: **\$0.00** copay

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Dental Services

#### Comprehensive dental services:<sup>1</sup>

This plan covers up to a **\$500.00** allowance for covered comprehensive dental services every year.

Doctors and dentists in our plan: **\$0.00** copay

We cover more dental care than what Original Medicare covers. You can use our coverage for these services and more: extra exams, cleanings, X-rays, fillings and repairs, root canals (endodontics), dental crowns (caps), bridges and implants, and dentures.

Any amount not used at the end of the calendar year will expire.

This plan covers up to a **\$500.00** allowance for covered comprehensive dental services every year.

Doctors and dentists in our plan: **\$0.00** copay

We cover more dental care than what Original Medicare covers. You can use our coverage for these services and more: extra exams, cleanings, X-rays, fillings and repairs, root canals (endodontics), dental crowns (caps), bridges and implants, and dentures.

Any amount not used at the end of the calendar year will expire.

To find a dental provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Dental Provider** under **Provider Type**.

### Vision Services

#### Medicare-covered vision services:

#### Exam to diagnose and treat diseases and conditions of the eye

Doctors in our plan: **\$0.00 - \$35.00** copay

Doctors in our plan: **\$0.00 - \$35.00** copay

#### Eyeglasses or contact lenses after cataract surgery

Doctors in our plan: **\$0.00** copay

Doctors in our plan: **\$0.00** copay

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Vision Services

#### Routine vision services:

##### Routine vision exam

This plan covers 1 routine eye exam(s) every year.

Doctors in our plan: **\$0.00** copay

This plan covers 1 routine eye exam(s) every year.

Doctors in our plan: **\$0.00** copay

##### Routine eyewear (lenses and frames)

This plan covers up to **\$175.00** for eyeglasses or contact lenses every year.

Doctors in our plan: **\$0.00** copay

This plan covers up to **\$175.00** for eyeglasses or contact lenses every year.

Doctors in our plan: **\$0.00** copay

To find a vision provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Vision Provider** under **Provider Type**.

### Mental Health Care

#### Inpatient visit:<sup>1</sup>

Doctors and facilities in our plan: Days 1-5: **\$200.00** per day, per admission / Days 6-90: **\$0.00** per day, per admission

Doctors and facilities in our plan: Days 1-5: **\$200.00** per day, per admission / Days 6-90: **\$0.00** per day, per admission

Our plan covers unlimited inpatient days. Per day cost sharing applies to each new inpatient admission. (Note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost sharing per day applies).

**Amerivantage Lung Care Plus  
(HMO C-SNP)**
**Amerivantage Heart Care Plus  
(HMO C-SNP)**
**Mental Health Care**
**Outpatient individual and group therapy services:<sup>1</sup>**

Outpatient mental health services using doctors and facilities in our plan: **\$35.00** copay

Outpatient group or individual therapy visit at a network psychiatrist's office: **\$35.00** copay

Outpatient mental health services using doctors and facilities in our plan: **\$35.00** copay

Outpatient group or individual therapy visit at a network psychiatrist's office: **\$35.00** copay

Your copay for services received through select locations is **\$0.00**.

**Skilled Nursing Facility (SNF)<sup>1</sup>**

Doctors and facilities in our plan: SNF Days 1 - 20: **\$0.00** per day / Days 21 - 100: **\$75.00** per day

Doctors and facilities in our plan: SNF Days 1 - 20: **\$0.00** per day / Days 21 - 100: **\$75.00** per day

Our plan covers up to 100 days in a Skilled Nursing Facility (SNF). Your copays for SNF benefits are based on benefit periods. A benefit period starts on the first day you go into a hospital or SNF and ends when you haven't had any inpatient hospital care or skilled nursing care for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period starts. There's no limit to the number of benefit periods you can have.

**Physical Therapy<sup>1</sup>**

Provided through select locations: **\$0.00** copay  
Other doctors and facilities in our plan: **\$15.00** copay

Provided through select locations: **\$0.00** copay  
Other doctors and facilities in our plan: **\$15.00** copay



## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Ambulance<sup>1</sup>

#### Ground/Water Ambulance:

Emergency transportation services in our plan: **\$195.00** copay per trip

Emergency transportation services in our plan: **\$195.00** copay per trip

#### Air Ambulance:

Emergency transportation services in our plan: **\$195.00** copay per trip

Emergency transportation services in our plan: **\$195.00** copay per trip

For ground or water ambulance, your cost share will be waived if you are transferred between like facilities, from an inpatient hospital to a skilled nursing facility, or from a facility to home. For air ambulance, your cost share will be waived if you are transferred between like facilities or from an inpatient hospital to a skilled nursing facility.

### Transportation

#### Plan approved locations

You pay a **\$0.00** copay. This plan offers coverage for 12, one-way, routine transportation services every year. Trips are limited to 60 miles.

#### Select locations

You pay a **\$0.00** copay for unlimited one-way trips to scheduled medical appointments and services provided through select locations.

#### Plan approved locations

You pay a **\$0.00** copay. This plan offers coverage for 12, one-way, routine transportation services every year. Trips are limited to 60 miles.

#### Select locations

You pay a **\$0.00** copay for unlimited one-way trips to scheduled medical appointments and services provided through select locations.

Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by contracted transportation vendors in our plan. If you need a ride, call us at least 48 hours ahead of time (excluding weekends). This plan allows you to select additional transportation benefits as part of the Essential Extras benefit. See that benefit description for more information.

**Amerivantage Lung Care Plus  
(HMO C-SNP)**
**Amerivantage Heart Care Plus  
(HMO C-SNP)**
**Medicare Part B Drugs<sup>1</sup>**
**Other Part B Drugs:**

Drugs obtained from doctors and facilities in our plan: **\$0.00** copay - **20%** coinsurance

Drugs obtained from doctors and facilities in our plan: **\$0.00** copay - **20%** coinsurance

**Chemotherapy drugs:**

Drugs obtained from doctors and facilities in our plan: **20%** coinsurance

Drugs obtained from doctors and facilities in our plan: **20%** coinsurance

The minimum copay for Other Medicare Part B drugs applies to select covered drugs administered by durable medical equipment, including mail order prescriptions, and provided at select locations for acute management of chronic disease.

## Additional benefits

### Everyday Extras

#### Amerivantage Lung Care Plus (HMO C-SNP):

Offered

#### Amerivantage Heart Care Plus (HMO C-SNP):

Offered

We want you to have not just the best possible health, but comfort in your daily life. Choose **any one** of the following innovative benefits as part of a comprehensive plan that we will help you create.



#### Assistive Devices

You will receive an annual spending allowance of **\$500** for assistive and safety devices, such as hand rails, shower stools, raised toilet seats, and temporary mobility ramps.



#### Flex Account – Dental, Vision, Hearing

Enjoy a **\$500** annual spending allowance for your dental, vision, and/or hearing needs. You get to choose how to use your annual spending allowance - toward out-of-pocket costs or additional services.



#### Healthy Groceries

If you have a diagnosed chronic condition, you will receive a monthly spending allowance of **\$50** toward the purchase of healthy groceries at participating stores near you. Select healthy groceries are also available online.



#### Flex Account - Utilities

If you have a diagnosed chronic condition, you can receive a **\$50** monthly spending allowance toward the payment of household utilities including gas, electric, water, or sewer. It can also be used with your internet and cellular providers.



#### In-Home Support

Enjoy up to 60 hours per year of companionship and support with independent activities of daily living such as light chores, errands, and more.



#### Transportation

Get up to 60 one-way rides per year to plan-approved locations.

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Adult Day Center

You could visit a licensed adult day center once a week (up to 8 hours per visit) and be reimbursed up to **\$80** if you need help with 2 or more activities of daily living. This benefit includes rides to and from the center. You'll experience supervised care and the chance to socialize, and your caregiver will gain a respite.

You could visit a licensed adult day center once a week (up to 8 hours per visit) and be reimbursed up to **\$80** if you need help with 2 or more activities of daily living. This benefit includes rides to and from the center. You'll experience supervised care and the chance to socialize, and your caregiver will gain a respite.

### Chiropractic Care<sup>1</sup>

#### Medicare-covered chiropractic services:

Providers in our plan: **\$20.00** copay

Providers in our plan: **\$20.00** copay

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

### Electronic Health Monitoring

Covers in-home equipment and telecommunication technology to monitor specific health conditions

Covers in-home equipment and telecommunication technology to monitor specific health conditions

**Amerivantage Lung Care Plus  
(HMO C-SNP)**

**Amerivantage Heart Care Plus  
(HMO C-SNP)**

**Foot Care** (podiatry services) <sup>1</sup>

**Medicare-covered podiatry:**

Provided through select locations: **\$0.00** copay  
Other doctors in our plan: **\$35.00** copay

Provided through select locations: **\$0.00** copay  
Other doctors in our plan: **\$35.00** copay

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.

**Routine foot care:**

Provided through select locations: **\$0.00** copay  
Other doctors in our plan: **\$35.00** copay  
This plan covers: 12 routine foot care visits each year.

Provided through select locations: **\$0.00** copay  
Other doctors in our plan: **\$35.00** copay  
This plan covers: 12 routine foot care visits each year.

**Healthy Meals - Chronic Condition**

**\$0.00** copay for up to 2 meals a day for 90 days to support your chronic condition nutritional needs.

**\$0.00** copay for up to 2 meals a day for 90 days to support your chronic condition nutritional needs.

You must use network providers.

**Healthy Meals - Post Discharge**

**\$0.00** copay for up to 2 meals a day for 7 days following your discharge from the hospital or skilled nursing facility (SNF).

**\$0.00** copay for up to 2 meals a day for 7 days following your discharge from the hospital or skilled nursing facility (SNF).

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Healthy Pantry<sup>1</sup>

If you have a diagnosed chronic condition, you could receive monthly nutritional counseling sessions and monthly delivery of non-perishable pantry staples to help you make important changes to your diet.

If you have a diagnosed chronic condition, you could receive monthly nutritional counseling sessions and monthly delivery of non-perishable pantry staples to help you make important changes to your diet.

### Home Health Care<sup>1</sup>

Doctors and facilities in our plan: **\$0.00** copay

Doctors and facilities in our plan: **\$0.00** copay

### LiveHealth<sup>®</sup> Online

Lets you talk to a board-certified doctor or licensed psychiatrist, psychologist, or therapist by live, two-way video on a computer, smartphone, or tablet

Lets you talk to a board-certified doctor or licensed psychiatrist, psychologist, or therapist by live, two-way video on a computer, smartphone, or tablet

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of our plan.

### Medical Equipment/Supplies

#### Durable Medical Equipment (wheelchairs, oxygen, etc.):<sup>1</sup>

Suppliers in our plan: **\$0.00** copay applies for DME less than **\$500.00**. **20%** coinsurance applies for DME greater than or equal to **\$500.00**.

Suppliers in our plan: **\$0.00** copay applies for DME less than **\$500.00**. **20%** coinsurance applies for DME greater than or equal to **\$500.00**.

**Amerivantage Lung Care Plus  
(HMO C-SNP)**

**Amerivantage Heart Care Plus  
(HMO C-SNP)**

**Medical Equipment/Supplies**

**Medical supplies and prosthetic devices** (braces, artificial limbs, etc.):<sup>1</sup>

Suppliers in our plan: **\$0.00** copay for prosthetics & supplies less than **\$500.00**. **20%** coinsurance for prosthetics and supplies greater than or equal to **\$500.00**.

Suppliers in our plan: **\$0.00** copay for prosthetics & supplies less than **\$500.00**. **20%** coinsurance for prosthetics and supplies greater than or equal to **\$500.00**.

**Diabetic supplies and services:**<sup>1</sup>

Suppliers in our plan: **\$0.00** copay

Suppliers in our plan: **\$0.00** copay

**Medicare Community Resource Support**

We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs. Call us at the number listed on your plan ID card and ask for the Medicare Community Resource Support team for more details.

We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs. Call us at the number listed on your plan ID card and ask for the Medicare Community Resource Support team for more details.

**Amerivantage Lung Care Plus  
(HMO C-SNP)**
**Amerivantage Heart Care Plus  
(HMO C-SNP)**
**Outpatient Rehabilitation**

**Cardiac (heart) rehab services** (with a limit of two, one-hour sessions per day and a maximum of 36 sessions within a 36-week period):<sup>1</sup>

Doctors and facilities in our plan: **\$25.00**  
copay

Doctors and facilities in our plan: **\$25.00**  
copay

**Pulmonary (lung) rehab services** (with a limit of two, one-hour sessions per day and a maximum of 36 sessions):<sup>1</sup>

Doctors and facilities in our plan: **\$20.00**  
copay

Doctors and facilities in our plan: **\$20.00**  
copay

**Occupational therapy visit:<sup>1</sup>**

Doctors and facilities in our plan: **\$15.00**  
copay

Doctors and facilities in our plan: **\$15.00**  
copay

**Outpatient Substance Abuse<sup>1</sup>**
**Individual & Group therapy visit:**

Doctors and facilities in our plan: **\$30.00**  
copay

Doctors and facilities in our plan: **\$30.00**  
copay



## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Over-the-Counter Items

Get a spending allowance of **\$100** every quarter for certain approved, non-prescription, over-the-counter drugs and health-related items.

Here are the ways you can use your benefit:

- Shop at participating stores near you.
- Shop online, use the app, or call to place an order and have items delivered to your home.

Get a spending allowance of **\$100** every quarter for certain approved, non-prescription, over-the-counter drugs and health-related items.

Here are the ways you can use your benefit:

- Shop at participating stores near you.
- Shop online, use the app, or call to place an order and have items delivered to your home.

### Pest Control

If you have a diagnosed chronic condition, you can have your home treated every three months for standard pests or get a one time treatment for certain infestations that have a direct impact on your health.

If you have a diagnosed chronic condition, you can have your home treated every three months for standard pests or get a one time treatment for certain infestations that have a direct impact on your health.

### Renal Dialysis

Doctors and facilities in our plan: **\$0.00** copay

Doctors and facilities in our plan: **\$0.00** copay

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### SilverSneakers<sup>®†</sup> Fitness program

When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **www.silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday to Friday, 8 a.m. to 8 p.m. ET.

When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **www.silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday to Friday, 8 a.m. to 8 p.m. ET.

†The SilverSneakers Fitness Program is provided by Tivity Health, an independent company. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.

### 24-Hour Nurse HelpLine

24-hour access to a nurse helpline, seven days a week, 365 days a year

24-hour access to a nurse helpline, seven days a week, 365 days a year

Services with a 1 may need prior authorization (preapproval) from the plan.



## Summary of 2023 prescription drug coverage

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### Ways to save

1. Choose generic drugs on tiers 1 and 2 when available.
2. Use mail order.
3. Use a preferred pharmacy. To find a preferred pharmacy in this plan:
  - Visit <https://shop.amerigroup.com/medicare> (select **Useful Tools**, and choose **Find a Pharmacy**). Preferred pharmacies are noted to the right of the pharmacy name.
  - Give us a call and we will send you a copy of the *Pharmacy Directory*.

**Amerivantage Lung Care Plus (HMO C-SNP)****Amerivantage Heart Care Plus (HMO C-SNP)****Stage 1: How much is my deductible?**

This plan does not have a Part D deductible.

This plan does not have a Part D deductible.

**Stage 2: Initial Coverage**

After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach **\$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach **\$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your covered drugs at retail pharmacies and mail-order pharmacies in our plan. Generally, you may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan. If you live in a long-term care facility, you pay the same as at a standard retail pharmacy.

If you qualify for low-income subsidy (LIS), also known as Medicare's Extra Help program, the amount you pay may be different in this Stage.

<b>Stage 2: Initial Coverage</b>		
<b>Cost Sharing</b>	<b>Amerivantage Lung Care Plus (HMO C-SNP)</b>	<b>Amerivantage Heart Care Plus (HMO C-SNP)</b>
<b>Tier 1: Preferred Generic</b>		
Preferred retail one-month supply	<b>\$0.00</b>	<b>\$0.00</b>
Standard retail one-month supply	<b>\$5.00</b>	<b>\$5.00</b>
Mail order three-month supply	<b>\$0.00</b>	<b>\$0.00</b>
<b>Tier 2: Generic</b>		
Preferred retail one-month supply	<b>\$7.50</b>	<b>\$7.50</b>
Standard retail one-month supply	<b>\$12.50</b>	<b>\$12.50</b>
Mail order three-month supply	<b>\$0.00</b>	<b>\$0.00</b>
<b>Tier 3: Preferred Brand</b>		
Preferred retail one-month supply	<b>\$40.00</b>	<b>\$40.00</b>
Standard retail one-month supply	<b>\$45.00</b>	<b>\$45.00</b>
Mail order three-month supply	<b>\$80.00</b>	<b>\$80.00</b>

## Stage 2: Initial Coverage

Cost Sharing	Amerivantage Lung Care Plus (HMO C-SNP)	Amerivantage Heart Care Plus (HMO C-SNP)
<b>Tier 4: Non-Preferred Drug</b>		
Preferred retail one-month supply	<b>\$85.00</b>	<b>\$85.00</b>
Standard retail one-month supply	<b>\$95.00</b>	<b>\$95.00</b>
Mail order three-month supply	<b>\$170.00</b>	<b>\$170.00</b>
<b>Tier 5: Specialty Tier</b>		
Preferred retail one-month supply	<b>33%</b>	<b>33%</b>
Standard retail one-month supply	<b>33%</b>	<b>33%</b>
Mail order three-month supply	<b>Not available</b>	<b>Not available</b>
<b>Tier 6: Select Care Drugs</b>		
Preferred retail one-month supply	<b>\$0.00</b>	<b>\$0.00</b>
Standard retail one-month supply	<b>\$0.00</b>	<b>\$0.00</b>
Mail order three-month supply	<b>\$0.00<sup>100</sup></b>	<b>\$0.00<sup>100</sup></b>

<sup>100</sup>The three-month supply for this tier on this plan is 100 days.

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Stage 3: Coverage Gap

After your total yearly drug costs reach **\$4,660**, you receive limited coverage by the plan on certain drugs. You will continue to pay your ICL cost share for Tier 1 preferred generic drugs, Tier 2 generic drugs, and some Tier 6 select care drugs in the coverage gap. You will also receive a discount on brand name drugs and generally pay no more than **25%** of the plan's costs for other formulary brand drugs and **25%** of the plan's costs for other formulary generic drugs until your yearly out-of-pocket drug costs reach **\$7,400**.

After your total yearly drug costs reach **\$4,660**, you receive limited coverage by the plan on certain drugs. You will continue to pay your ICL cost share for Tier 1 preferred generic drugs, Tier 2 generic drugs, and some Tier 6 select care drugs in the coverage gap. You will also receive a discount on brand name drugs and generally pay no more than **25%** of the plan's costs for other formulary brand drugs and **25%** of the plan's costs for other formulary generic drugs until your yearly out-of-pocket drug costs reach **\$7,400**.

### Stage 4: Catastrophic Coverage

After your yearly out-of-pocket drug costs reach **\$7,400**: For tiers 1 and 6, you pay **\$0.00**. For tiers 2 - 5, you pay the greater of: a **\$4.15** copay for generic (including brand drugs treated as generic) and a **\$10.35** copay for all other drugs, or **5%** coinsurance.

After your yearly out-of-pocket drug costs reach **\$7,400**: For tiers 1 and 6, you pay **\$0.00**. For tiers 2 - 5, you pay the greater of: a **\$4.15** copay for generic (including brand drugs treated as generic) and a **\$10.35** copay for all other drugs, or **5%** coinsurance.







## Optional supplemental dental and vision plans

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You can add an optional supplemental benefit plan to this plan, and take advantage of:

- No yearly deductibles.
- No waiting periods for coverage.
- Your choice of many dentists and vision care providers.

## Package 1: Preventive Dental Package

### Amerivantage Lung Care Plus (HMO C-SNP)

### Amerivantage Heart Care Plus (HMO C-SNP)

#### How much is the monthly payment?

An extra **\$12.00** per month. You must keep paying your Medicare Part B monthly payment.

An extra **\$12.00** per month. You must keep paying your Medicare Part B monthly payment.

#### How much is the deductible?

This package does not have a deductible.

This package does not have a deductible.

#### Is there a limit on how much the plan will pay?

##### Doctors in our plan:

- The plan will pay up to **\$500.00** for the following preventive dental benefits each year (benefit maximum).

##### Doctors in our plan:

- The plan will pay up to **\$500.00** for the following preventive dental benefits each year (benefit maximum).

Talk to your doctor and confirm all coverage, costs and codes before you receive services.

#### Benefits included:

##### Doctors in our plan:

You pay no copay for:

- Two exams
- Two cleanings

##### Doctors in our plan:

You pay no copay for:

- Two exams
- Two cleanings

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Benefits included:

- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- Two fluoride treatments

- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- Two fluoride treatments

Since these services are not normally covered under Original Medicare, we offer them as a Supplemental Benefit for an extra monthly payment through this Optional Supplemental Package.

## Package 2: Dental and Vision Package

### Amerivantage Lung Care Plus (HMO C-SNP)

### Amerivantage Heart Care Plus (HMO C-SNP)

#### How much is the monthly payment?

An extra **\$24.00** per month. You must keep paying your Medicare Part B monthly payment.

An extra **\$24.00** per month. You must keep paying your Medicare Part B monthly payment.

#### How much is the deductible?

This package does not have a deductible.

This package does not have a deductible.

#### Is there a limit on how much the plan will pay?

##### Doctors in our plan:

- The plan will pay up to **\$1,000.00** for the following preventive dental benefits each year (benefit maximum).

##### Doctors in our plan:

- The plan will pay up to **\$1,000.00** for the following preventive dental benefits each year (benefit maximum).

Talk to your doctor and confirm all coverage, costs, and codes before you receive services.

#### Benefits included:

##### Dental:

##### Doctors in our plan:

You pay no copay for:

##### Doctors in our plan:

You pay no copay for:

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Benefits included:

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- Two fluoride treatments

You pay **20%** of the covered charges for certain restorative dental services (fillings).

You pay **50%** of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions

Exclusions & Limits for this benefit package:

- Dentures and crowns are excluded.
- Coverage is only available from network providers.

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- Two fluoride treatments

You pay **20%** of the covered charges for certain restorative dental services (fillings).

You pay **50%** of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions

Exclusions & Limits for this benefit package:

- Dentures and crowns are excluded.
- Coverage is only available from network providers.

### Vision:

This package offers a **\$150.00** reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames, and/or contact lenses.

This package offers a **\$150.00** reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames, and/or contact lenses.

**Amerivantage Lung Care Plus  
(HMO C-SNP)****Amerivantage Heart Care Plus  
(HMO C-SNP)****Benefits included:**

Talk to your provider and confirm all coverage, costs, and codes prior to services being rendered.

Exclusions & limits for this benefit package:

- Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.
- Coverage is only available from network providers.

Talk to your provider and confirm all coverage, costs, and codes prior to services being rendered.

Exclusions & limits for this benefit package:

- Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.
- Coverage is only available from network providers.

Since these services are not normally covered under Original Medicare, we offer them as a Supplemental Benefit for an extra monthly payment through this Optional Supplemental Package.

## Package 3: Enhanced Dental and Vision Package

### Amerivantage Lung Care Plus (HMO C-SNP)

### Amerivantage Heart Care Plus (HMO C-SNP)

#### How much is the monthly payment?

An extra **\$45.00** per month. You must keep paying your Medicare Part B monthly payment.

An extra **\$45.00** per month. You must keep paying your Medicare Part B monthly payment.

#### How much is the deductible?

This package does not have a deductible.

This package does not have a deductible.

#### Is there a limit on how much the plan will pay?

##### Doctors in our plan:

- The plan will pay up to **\$2,000.00** for the following preventive dental benefits each year (benefit maximum).

##### Doctors in our plan:

- The plan will pay up to **\$2,000.00** for the following preventive dental benefits each year (benefit maximum).

Talk to your doctor and confirm all coverage, costs and codes before you receive services.

#### Benefits included:

##### Dental:

##### Doctors in our plan:

You pay no copay for:

##### Doctors in our plan:

You pay no copay for:

## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Benefits included:

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- Two fluoride treatments

You pay **20%** of the covered charges for certain restorative dental services (fillings).

You pay **50%** of the covered charges for certain endodontic, periodontic, prosthodontic and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions
- Crowns (once per tooth every five years)
- Complete denture, immediate denture, or partial denture (one set of dentures every five years)
- Denture adjustment, repair, replacement, rebasing and relining
- Local anesthesia (a drug to numb a part of the body) or regional block anesthesia
- Dental implants

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- Two fluoride treatments

You pay **20%** of the covered charges for certain restorative dental services (fillings).

You pay **50%** of the covered charges for certain endodontic, periodontic, prosthodontic and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions
- Crowns (once per tooth every five years)
- Complete denture, immediate denture, or partial denture (one set of dentures every five years)
- Denture adjustment, repair, replacement, rebasing and relining
- Local anesthesia (a drug to numb a part of the body) or regional block anesthesia
- Dental implants



## Amerivantage Lung Care Plus (HMO C-SNP)

## Amerivantage Heart Care Plus (HMO C-SNP)

### Benefits included:

#### Vision:

This package offers a **\$200.00** reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames, and/or contact lenses.

Talk to your provider and confirm all coverage, costs, and codes prior to services being rendered.

Exclusions & limits for this benefit package:

- Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.
- Coverage is only available from network providers.

This package offers a **\$200.00** reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames, and/or contact lenses.

Talk to your provider and confirm all coverage, costs, and codes prior to services being rendered.

Exclusions & limits for this benefit package:

- Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.
- Coverage is only available from network providers.

Since these services are not normally covered under Original Medicare, we offer them as a Supplemental Benefit for an extra monthly payment through this Optional Supplemental Package.

# An overview of how Medicare works

If you're new to Medicare, this can help you decide what option is right for you.

**Original Medicare (Parts A and B) is a federal government program that helps cover:**





- Inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care).
- Hospice and some home healthcare services.
- Doctor services, hospital outpatient care, lab tests, medical equipment, and supplies.
- Most preventive services, including a yearly wellness exam.

**Original Medicare (Parts A and B) does not cover:**

- Prescription drugs.
- Vision, dental, or hearing care.



## Here are your options

Option 1: an all-in-one Medicare Advantage plan	Option 2: One or both of the following
<p>Medicare Part C</p> <h3>C+D+Extras</h3> <ul style="list-style-type: none"> <li><input type="checkbox"/> Includes all of Part A (hospital) and Part B (medical) coverage</li> <li><input type="checkbox"/> Usually includes Part D prescription drug coverage</li> <li><input type="checkbox"/> Often offers extra services and benefits</li> <li><input type="checkbox"/> Caps what you'll pay out-of-pocket for medical services</li> </ul>	<p><b>Medicare Supplement</b> </p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medicare Part A or Part B deductibles, coinsurance, or copayments</li> <li><input type="checkbox"/> Medicare Part B excess charges</li> <li><input type="checkbox"/> Skilled nursing facility care coinsurance</li> <li><input type="checkbox"/> Foreign travel emergencies</li> </ul> <hr/> <p> <b>Medicare Part D</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Helps pay for many of your prescribed drugs</li> <li><input type="checkbox"/> Gives you access to mail-order services and pharmacies across the country</li> </ul>

# The four stages of drug coverage

To understand your plan's specific coverage for each stage, see the **Summary of 2023 prescription drug coverage** section of this Summary of Benefits.



Stage 1	Stage 2	Stage 3	Stage 4
Deductible	Initial Coverage	Coverage Gap	Catastrophic Coverage
<p>If you have a deductible, you pay <b>100%</b> of your drug costs until you meet your deductible.</p> <p>If you have no deductible, or if a specific drug tier does not apply to the deductible, you will skip to Stage 2.</p>	<p>You pay a copay or a percentage of the cost, and your plan pays the rest for your covered drugs.</p>	<p>In this stage, you pay a greater share of the costs. It begins after you and your plan have paid a certain amount on covered drugs during Stages 1 and 2 (this can vary by plan). See <b>Stage 2: Initial Coverage</b> in the prescription drug coverage section of this Summary of Benefits for the exact amount.</p> <p>After you enter the coverage gap, you pay a percentage of the plan's cost for covered brand-name drugs and/or covered generic drugs until your costs total <b>\$7,400</b>.</p> <p>Some plans have extra coverage. See the <b>Stage 3: Coverage Gap</b> section for more details.</p>	<p>In this stage, after your yearly out-of-pocket drug costs (including drugs purchased through mail order and pharmacy) reach <b>\$7,400</b>, the plan pays most, or in some cases, all, of covered drug costs. This stage lasts until the end of the plan year.</p> <p>See the <b>Stage 4: Catastrophic Coverage</b> section for what you pay with this plan.</p>

## Which coverage stage am I in?

You will receive an **Explanation of Benefits (EOB)** each month you fill a prescription. It will show which coverage stage you're in and how close you are to entering the next one.

# When you can enroll

## Initial Enrollment Period



You can sign up for a Medicare Advantage or Part D plan when you are first eligible for Medicare. Your Initial Enrollment Period is a seven-month period that includes the three months before your 65<sup>th</sup> birthday month, the month you turn 65, and the three months after your 65<sup>th</sup> birthday month.

## Annual Enrollment Period - October 15 to December 7



This is the time each year to enroll in or change your Medicare Advantage or Part D plan. You may also switch to Original Medicare (Parts A and B). New coverage begins January 1 of each year.

## Open Enrollment Period - January 1 to March 31



This is an extra time each year when you can make one enrollment change to your existing Medicare Advantage plan. You can do one of the following:

- Move to a different Medicare Advantage plan
- Drop your Medicare Advantage plan to stay with Original Medicare. If you do this and need drug coverage, you have until March 31 to add a Medicare Part D (prescription drug) plan.

## Special Enrollment Period

You can sign up for a Medicare Advantage or Part D plan outside of the standard time frames if certain events occur in your life. These events may include (but aren't limited to) a change in employment, circumstances, or location.

## Medicare ID cards

If you choose a Medicare Advantage and Prescription Drug plan:



You will not need your red, white and blue Medicare ID card. Just present your member ID card for all your covered medical and drug benefits.

## Avoid late-enrollment penalties

It's important to enroll in a Medicare plan when you're first eligible. If you don't, you may have to pay the following penalties:



**Medicare Part A:** You may have to buy Part A if you don't qualify for premium-free Part A. If you do not buy it when you're first eligible for Medicare, your monthly premium may go up 10%. You will have to pay the higher premium for twice the number of years you didn't sign up.

For example, if you delayed enrollment for one year and your monthly Part A premium was \$100, then you would have to pay a \$110 (10% increase) premium for two years (two times the one year you didn't have Medicare Part A).



**Medicare Part B:** Your monthly premium may increase 10% for each 12-month period that you could have had Part B but didn't sign up. You'll have to pay this penalty for as long as you have Part B.



**Medicare Part D:** If you don't sign up when you're first eligible, you may have to pay this penalty for as long as you are enrolled in Part D, and it may increase every year. You may not have to pay it if you receive Extra Help or have proof of other creditable (as good as Medicare's) coverage.

## How can I learn more about Medicare?

### Medicare & You, a helpful tool



The United States government's *Medicare & You* handbook is a great way to learn about Medicare and find answers to your questions. If you do not have a copy, you can view it online at [medicare.gov](https://www.medicare.gov) or call Medicare for a copy at **1-800-MEDICARE (1-800-633-4227)**, 24/7. TTY users can call **1-877-486-2048**.

Hay disponibles servicios de traducción; póngase en contacto con el plan o su agente.

If you need emergency or urgent care, call 911 or go to the nearest doctor or facility that can help you. Most times, you must use doctors in our plan to receive covered medical care, except for emergencies and urgently needed care when doctors in our plan are not available or dialysis services when you are out of the service area. If you receive routine care from doctors outside our plan, neither Medicare nor Amerigroup will pay for it.

Some benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify.

Amerigroup Ohio, Inc. is an HMO C-SNP plan with a Medicare contract. Enrollment in Amerigroup Ohio, Inc. depends on contract renewal.

## Multi-Language Insert

### Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-816-2790. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-816-2790. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-816-2790。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-816-2790。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-816-2790. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-816-2790. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-816-2790 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-816-2790. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-816-2790번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика,

позвоните нам по телефону 1-888-816-2790. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري ليس عليك سوى الاتصال بنا على 1-888-816-2790. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-816-2790 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-816-2790. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-816-2790. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-816-2790. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-816-2790. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-816-2790にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。



## IMPORTANT INFORMATION:

2022 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



Amerigroup - H1423

**For 2022, Amerigroup - H1423 received the following Star Ratings from Medicare:**

**Overall Star Rating:** Plan too new to be measured

**Health Services Rating:** Plan too new to be measured

**Drug Services Rating:** Plan too new to be measured

*\*Some plans do not have enough data to rate performance.*

**Every year, Medicare evaluates plans based on a 5-star rating system.**

### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

**The number of stars show how well a plan performs.**

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

### Questions about this plan?

Contact Amerigroup 7 days a week from 8 a.m. to 8 p.m., (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 at 1-877-211-6614 (toll-free) or 711 (TTY).

Current members please call 1-888-816-2790 (toll-free) or 711 (TTY).

Amerigroup Ohio, Inc. is an HMO C-SNP plan with a Medicare contract. Enrollment in Amerigroup Ohio, Inc. depends on contract renewal.

## Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-877-211-6614** TTY: **711**, 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

### Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit <https://shop.amerigroup.com/medicare> or call **1-877-211-6614** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.