Amerigroup

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

2022 Summary of Benefits

Member Services: **1-855-878-1784** (TTY: **711**)
Monday through Friday from 8 a.m. to 8 p.m. local time
www.myamerigroup.com/TXmmp

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Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan): Summary of Benefits 2022

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Introduction

This document is a brief summary of the benefits and services covered by Amerigroup STAR+PLUS MMP. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Amerigroup STAR+PLUS MMP. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan): Summary of Benefits 2022

A. Disclaimers

This is a summary of health services covered by Amerigroup STAR+PLUS MMP for 2022. This is only a summary. Please read the *Member Handbook* for the full list of benefits. To get a printed *Member Handbook* at no extra cost, please call Member Services at **1-855-878-1784** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. local time. This call is free. You can also visit us at www.myamerigroup.com/TXmmp to access or order a *Member Handbook*.

- Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.
- For additional information you may also call the STAR+PLUS help line at 1-877-782-6440, Monday through Friday from 8 a.m. to 6 p.m. Central time. TTY users should call 711 or 1-800-735-2989.
- Under Amerigroup STAR+PLUS MMP you can get your Medicare and Texas Medicaid services in one health plan. An Amerigroup STAR+PLUS MMP Service Coordinator will help manage your health care needs.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the *Member Handbook*.
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-855-878-1784** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. local time. The call is free.
- ATENCIÓN: Si habla español, le ofrecemos servicios de asistencia de idiomas sin cargo. Llame al **1-855-878-1784** (TTY: **711**), de lunes a viernes, de 8 a.m. a 8 p.m., hora local. La llamada es gratuita.
- You can get this document for free in other formats, such as large print, braille, or audio. Call **1-855-878-1784** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. local time. The call is free.
    - You can get this document for free in other languages and formats, such as large print, braille, or audio. Call Member Services at the number listed on the bottom of this page. When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year.
    - You can also call us to change or cancel a standing order. You can also find your documents online at www.myamerigroup.com/TXmmp.

B. Frequently Asked Questions

The following chart lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicare-Medicaid Plan?	A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Medicaid. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Service Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
What is an Amerigroup STAR+PLUS MMP Service Coordinator?	An Amerigroup STAR+PLUS MMP Service Coordinator is one main person for you to contact. This person helps manage all your providers and services and makes sure you get what you need.
What are long-term services and supports?	Long-term services and supports are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital.
Will I get the same Medicare and Texas Medicaid benefits in Amerigroup STAR+PLUS MMP that I get now? (continued on the next page)	You will get your covered Medicare and Texas Medicaid benefits directly from Amerigroup STAR+PLUS MMP. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. You will get almost all of your covered Medicare and Texas Medicaid benefits directly from Amerigroup STAR+PLUS MMP, but you may get some benefits the same way you do now, outside of the plan. When you enroll in Amerigroup STAR+PLUS MMP, you and your service coordination team will work together to develop a Plan of Care to address your health and support needs. During this

Frequently Asked Questions (FAQ)	Answers
Will I get the same Medicare and Texas Medicaid benefits in Amerigroup STAR+PLUS MMP that I get now? (continued from previous page)	time, you can keep using your doctors and getting your current services for 90 days, or 180 days if you are receiving long-term services and supports, or until your Plan of Care is complete. When you join our plan, if you are taking any Medicare Part D prescription drugs that Amerigroup STAR+PLUS MMP does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for Amerigroup STAR+PLUS MMP to cover your drug, if medically necessary.
Can I go to the same doctors I use now?	Often that is the case. If your providers (including doctors, therapists, and pharmacies) work with Amerigroup STAR+PLUS MMP and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." **You must use the providers in Amerigroup STAR+PLUS MMP's network**. • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of Amerigroup STAR+PLUS MMP's plan. The exceptions to this rule are when you need urgent or emergency care or dialysis and cannot get to a provider in the plan, such as when you are away from home. You can also go outside the plan for other non-emergency services if Amerigroup STAR+PLUS MMP gives you permission first. To find out if your doctors are in the plan's network, call Member Services or read Amerigroup STAR+PLUS MMP's *Provider and Pharmacy Directory* on the plan's website at www.myamerigroup.com/TXmmp. If Amerigroup STAR+PLUS MMP is new for you, you can continue using the doctors you use now for 90 days, or 180 days if you are receiving long-term services and supports, or until your Plan of Care is complete. During that time, we will try to get your provider in our network.

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Frequently Asked Questions (FAQ)	Answers
What happens if I need a service but no one in Amerigroup STAR+PLUS MMP's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, Amerigroup STAR+PLUS MMP will pay for the cost of an out-of-network provider.
Where is Amerigroup STAR+PLUS MMP available?	The service area for this plan includes: Bexar, El Paso, Harris, and Tarrant Counties, Texas. You must live in one of these areas to join the plan.
Do I pay a monthly amount (also called a premium) under Amerigroup STAR+PLUS MMP?	You will not pay any monthly premiums to Amerigroup STAR+PLUS MMP for your health coverage.
What is prior authorization?	Prior authorization means that you must get approval from Amerigroup STAR+PLUS MMP before you can get a specific service or drug or use an out-of-network provider. Amerigroup STAR+PLUS MMP may not cover the service or drug if you don't get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. Refer to Chapter 3 of the *Member Handbook* to learn more about prior authorization. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a prior authorization.
What is a referral? (continued on the next page)	A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. If you don't get

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Frequently Asked Questions (FAQ)	Answers
What is a referral? (continued from previous page)	approval, Amerigroup STAR+PLUS MMP may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. Refer to Chapter 3 of the *Member Handbook* to learn more about when you will need to get a referral from your PCP.
What is Extra Help?	Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy" or "LIS". Your prescription drug copays under Amerigroup STAR+PLUS MMP already include the amount of Extra Help you qualify for. For more information about Extra Help, contact your local Social Security Office, or call Social Security at 1-800-772-1213. TTY users may call 1-800-325-0778.
Who should I contact if I have questions or need help? (continued on the next page)	**If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Amerigroup STAR+PLUS MMP Member Services:** **CALL** **1-855-878-1784** Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m. local time. Member Services also has free language interpreter services available for people who do not speak English. **TTY** **711** Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m. local time.

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Frequently Asked Questions (FAQ)	Answers
Who should I contact if I have questions or need help? (continued from previous page)	**If you have questions about your health, please call the Nurse Advice Call line:** **CALL** 1-855-878-1784 Calls to this number are free. 24 hours a day, 7 days a week. **TTY** 711 Calls to this number are free. 24 hours a day, 7 days a week. **If you need immediate behavioral health services, please call the Behavioral Health Crisis Line:** **CALL** 1-855-878-1784 Calls to this number are free. 24 hours a day, 7 days a week. **TTY** 711 Calls to this number are free. 24 hours a day, 7 days a week.

C. Overview of Services

The following chart is a quick overview of what services you may need, your costs and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor	Visits to treat an injury or illness	$0	
	Wellness visits, such as a physical	$0	
	Specialist care	$0	Prior authorization and referral may be required.
	Care to keep you from getting sick, such as flu shots	$0	
	"Welcome to Medicare" preventive visit (one time only)	$0	
You need medical tests	Lab tests, such as blood work	$0	Prior authorization may be required.
	X-rays or other pictures, such as CAT scans	$0	Prior authorization may be required.
	Screening tests, such as tests to check for cancer	$0	Prior authorization may be required.
You need drugs to treat your illness or condition (This service is continued on the next page)	Generic drugs (no brand name)	$0-$3.95 copay for up to a 93-day supply of covered Part D generic drugs. • Tier 1 $0 copay – Medicare Part D preferred generic	There may be limitations on the types of drugs covered. Please refer to Amerigroup STAR+PLUS MMP's *List of Covered Drugs* (Drug List) for more information. Some prescription drugs may require prior authorization.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Generic drugs (no brand name)	drugs (Up to a 93-day supply at a network retail or mail order pharmacy) • Tier 2 $0-$3.95 copay – Medicare Part D preferred and non-preferred generic drugs (Up to a 93-day supply at a network retail or mail order pharmacy) • Tier 3 $0 copay – Texas Medicaid/ state-approved non-Medicare covered prescription drugs (Up to a 31-day supply at a network retail pharmacy) • Tier 4 $0 copay – Texas Medicaid/state-approved	Our plan's network retail or mail order pharmacies allow you to order up to a 93-day extended supply of some Tier 1 and Tier 2 drugs. Your copay will be the same for the 31-day supply or a 93-day supply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Generic drugs (no brand name)	over-the-counter (OTC) drugs; covered OTC drugs require a prescription from your provider (Up to a 31-day supply at a network retail pharmacy) Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	
	Brand name drugs	$0-$9.85 copay for up to a 93-day supply of covered Part D brand name drugs. • Tier 1 $0 copay – Medicare Part D preferred brand name drugs (Up to a 93-day supply at a network retail or	There may be limitations on the types of drugs covered. Please refer to Amerigroup STAR+PLUS MMP's *List of Covered Drugs* (Drug List) for more information. Some prescription drugs may require prior authorization. Our plan's network retail or mail order pharmacies allow you to order up to a 93-day extended supply of some Tier 1 and Tier 2 drugs.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Brand name drugs	mail order pharmacy) • Tier 2 $0-$9.85 copay – Medicare Part D preferred and non-preferred brand name drugs (Up to a 93-day supply at a network retail or mail order pharmacy) • Tier 3 $0 copay – Texas Medicaid/state approved prescription brand name drugs (Up to a 31-day supply at a network retail pharmacy) • Tier 4 $0 copay – Texas Medicaid/state approved over-the-counter (OTC) drugs; covered OTC drugs	Your copay will be the same for the 31-day supply or a 93-day supply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Brand name drugs	require a prescription from your provider (Up to a 31-day supply at a network retail pharmacy) Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	
	Over-the-counter drugs	$0	There may be limitations on the types of drugs covered. Please refer to Amerigroup STAR+PLUS MMP's *List of Covered Drugs* (Drug List) for more information. Amerigroup STAR+PLUS MMP covers some OTC drugs with a written prescription from your provider. These drugs are in Tier 4 of the Drug List.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part B prescription drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs. There may be limitations on the types of drugs covered. Prior authorization may be required.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization may be required.
You need emergency care (This service is continued on the next page)	Emergency room services	$0	No prior authorization is required for emergency services. Out-of-network services are covered. Services are not covered outside the U.S. and its territories except under limited circumstances. Call Member Services for details.
	Ambulance services	$0	Medically necessary ambulance services are covered. Prior authorization may be required for nonemergency services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care (continued)	Urgent care	$0	No prior authorization is required for urgent care services. Out-of-network services are covered. Services are not covered outside the U.S. and its territories except under limited circumstances. Call Member Services for details.
You need hospital care	Hospital stay	$0	Except in an emergency, your doctor must tell the plan you are going to be admitted to the hospital. Limitations may apply. The plan offers thirty (30) additional days per benefit period. Prior authorization may be required.
	Doctor or surgeon care	$0	A doctor or surgeon's care is covered during a hospital stay. Except in an emergency, your doctor must tell the plan you are going to be admitted to the hospital. Prior authorization may be required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting better or have special health needs	Rehabilitation services	$0	In addition to the covered benefit, the plan offers 12 additional cardiac rehabilitation services visits each year. Prior authorization and referral may be required.
	Medical equipment for home care	$0	Prior authorization may be required.
	Skilled nursing care	$0	Prior authorization may be required.
You need eye care	Eye exams	$0	In addition to the Texas Medicaid benefit, the plan covers one routine eye exam every year. Prior authorization may be required.
	Glasses or contact lenses	$0	In addition to the Texas Medicaid benefit, the plan covers one pair of eyeglass lenses, frames, or contact lenses every year up to $300. Prior authorization may be required.
You need dental care (This service is continued on the next page)	Dental check-ups	$0	Diagnostic services such as: • One preventive dental exam every six months • One cleaning every six months • One set of dental X-rays every year

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)	Comprehensive dental care	$0	Up to $400 every three months or $1,600 a year. Benefits include: • Non-routine services such as fillings, extractions, root canals, crowns, bridges, and dentures • Diagnostic services • Restorative services • Endodontics, periodontics, and extractions Prior authorization may be required. Limitations apply. Call Member Services for details. Benefit differs for members qualified for and enrolled in a state-operated waiver program. Any amount remaining at the end of the year will not be carried over to the next year.
You need hearing/auditory services (This service is continued on the next page)	Hearing screenings	$0	Benefits include unlimited: • Routine hearing exams • Fitting/evaluations for hearing aids Prior authorization may be required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/auditory services (continued)	Hearing aids	$0	In addition to the Texas Medicaid benefit, the plan covers a maximum of $2,000 for up to 2 hearing aids every year, both ears combined. Prior authorization may be required.
You have a chronic condition, such as diabetes or heart disease	Services to help manage your disease	$0	Benefits include diabetes self-management training and kidney disease education. Limitations apply. Prior authorization may be required.
	Diabetes supplies and services	$0	Benefit includes: • Diabetic monitoring supplies • Custom-molded shoes and inserts or one pair of extra-depth shoes per year • Additional inserts provided based on your needs Limitations apply. Contact Member Services for a list of covered supplies. Prior authorization may be required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition	Mental or behavioral health services	$0	Benefit includes: • Individual therapy visits • Group therapy visits • Individual therapy visits with a psychiatrist • Group therapy visits with a psychiatrist • Partial hospitalization program services • Residential Treatment Facility • Inpatient hospitalization services Prior authorization may be required.
You have a substance abuse problem	Substance abuse services	$0	Benefit includes: • Individual substance abuse outpatient treatment visits • Group substance abuse outpatient treatment visits • Residential Treatment Facility • Inpatient hospitalization services Prior authorization may be required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need long-term mental health services	Inpatient care for people who need mental health care	$0	Unlimited inpatient days in a psychiatric hospital. Prior authorization may be required. Except in an emergency, your doctor must tell the plan you are going to be admitted to the hospital.
You need durable medical equipment (DME)	Wheelchairs	$0	Prior authorization may be required.
	Nebulizers	$0	Prior authorization may be required.
	Crutches	$0	Prior authorization may be required.
	Walkers	$0	Prior authorization may be required.
	Oxygen equipment and supplies	$0	Prior authorization may be required.
You need help living at home (This service is continued on the next page)	Meals brought to your home	$0	For waivered members, the plan covers home-delivered meals. Benefit requires qualification for and enrollment in a state-operated waiver program. Prior authorization may be required.
	Home services, such as cleaning or housekeeping	$0	Prior authorization may be required. State eligibility requirements may apply.
	Changes to your home, such as ramps and wheelchair access	$0	Benefits are limited: • Up to $7,500 maximum lifetime limit • Up to $300 annual limit

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	Changes to your home, such as ramps and wheelchair access	$0	Benefit requires qualification for and enrollment in a state-operated waiver program. Prior authorization may be required. Contact Member Services for more details.
	Personal care assistant (You may be able to employ your own assistant. Call Member Services for more information.)	$0	Prior authorization may be required. State eligibility requirements may apply.
	Training to help you get paid or unpaid jobs	$0	Benefit requires qualification for and enrollment in a state-operated waiver program. Prior authorization and referral may be required.
	Home health care services	$0	These services are available to all members based on need. Prior authorization may be required.
	Services to help you live on your own	$0	Benefit may require qualification for and enrollment in a state-operated waiver program. Prior authorization and referral may be required.
	Adult day services or other support services	$0	Prior authorization may be required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Assisted living or other housing services	$0	Benefit requires qualification for and enrollment in a state-operated waiver program. Prior authorization may be required.
	Nursing home care	$0	Services are available to members meeting specific level of care criteria. Prior authorization may be required.
Your caregiver needs some time off	Respite care	$0	The plan offers 30 days or up to 720 hours for members qualified for and enrolled in a state-operated waiver program. In addition, the plan offers eight hours of respite services annually for non-STAR+PLUS Waiver (SPW) members. This is provided in four-hour increments for two days or eight hours for one day. Covered places of service may include member's home or place of residence, foster homes, hospitals, nursing facilities, and other community care residential facilities. Prior authorization may be required.
You need transportation (These services are continued on the next page)	Ambulance services	$0	Prior authorization may be required for non-emergency ambulance services.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need transportation (continued)	Nonemergency Medical Transportation (NEMT) services to the doctor, dentist, hospital, pharmacy, and other places you get healthcare services	$0	Refer to Chapters 3 and 4 of *the Member Handbook* to learn more about NEMT services.
Additional covered services (These services are continued on the next page)	Home-delivered meals - post-discharge	$0	The plan covers home-delivered meals after you are released from the hospital, a skilled nursing facility, or a custodial nursing facility. This extra benefit covers two meals per day for five days. Prior authorization may be required.
	OTC Mail Order Catalog	$0	In addition to the Texas Medicaid benefit, the plan provides a $51 spending amount every three months for approved over-the-counter (OTC) medicines and health care-related items. These OTC medicines are delivered by mail order and do not require a prescription. Unused spending amounts will not carry from one quarter to the next quarter.
	A memory album for photos to encourage memory retention	$0	Photo albums may help to stimulate memories for a member suffering from Alzheimer's disease or other dementia. One photo album per lifetime. Must be diagnosed with Alzheimer's disease or other dementia. Talk to your Service Coordinator for more details. Prior authorization may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)	Membership in health club/fitness classes	$0	Membership in SilverSneakers® fitness program. SilverSneakers is not a gym membership but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. Members are instructed on the use of the contracted fitness centers' equipment and home self-paced exercise programs through an orientation of the program. The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.
	Personal Emergency Response System (PERS)	$0	Neck or wrist worn Personal Emergency Response Service (PERS) monitoring system for non-STAR+PLUS Waiver/non-STAR+PLUS Community First Choice members. Member must live in the community. Prior authorization may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)	Smoking and Tobacco Use Cessation	$0	Benefit includes cessation counseling and Nicotine Replacement Therapy (NRT) when prescribed.
	Counseling services	$0	Counseling services are included for medically necessary programs and/or topics such as: • Cardiac (heart) rehabilitation services • Alcohol misuse • Lung cancer • Medical nutrition therapy Review the *Member Handbook* for more medically necessary programs and/or topics. Prior authorization may be required.
	Medicare-covered Acupuncture for chronic low back pain	$0	Up to 12 visits in 90 days plus an additional 8 sessions if improvement is shown. Limited to 20 acupuncture treatments each year. As a flexible benefit, the plan also covers up to 6 acupuncture treatments every year.
	Podiatry services	$0	One (1) routine foot care visit is covered every three months. Prior authorization may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)	Pest control	$0	One treatment every three months to eliminate rodents, roaches, and other unsafe pests from the home in order to provide a healthier community-based environment for members. Prior authorization may be required.
	Opioid treatment services	$0	The plan will pay for the following services to treat opioid use disorder: • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) Prior authorization may be required.
	Supportive benefits and services	$0	The following are available to members who qualify: • Minor home modifications • Habilitation • Support management

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)	Supportive benefits and services		• Nursing services • Adult foster care • Transitional assistance services • Cognitive rehabilitation therapy • Adaptive aids and medical supplies • Support consultation • Family planning services • Free standing birth centers State eligibility requirements may apply or benefit requires qualification for and enrollment in a state-operated waiver program. Prior authorization and referral may be required.
	Day Activity and Health Services (DAHS)	$0	Daytime services for members residing in the community. Services may include but are not limited to nursing and personal care, noon meal and snacks, transportation, and social, educational, and recreational activities at no cost to the member. State eligibility requirements may apply or benefit requires qualification for and enrollment in a state-operated waiver program. Prior authorization and referral may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)	Personal assistance services	$0	The plan may cover the following services, if medically or functionally necessary, and some other services not listed here: • Grooming • Eating • Bathing • Dressing and personal hygiene • Functional living tasks / assistance with planning and preparing meals Prior authorization and referral may be required.
	24-Hour Nurse HelpLine	$0	As a member, you have access to a 24-Hour Nurse HelpLine, 7 days a week, 365 days a year. When you call our Nurse HelpLine, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the 24-Hour Nurse HelpLine at 1-855-878-1784. TTY users should call 711.

D. Services covered outside of Amerigroup STAR+PLUS MMP

This is not a complete list. Call Member Services to find out about other services not covered by Amerigroup STAR+PLUS MMP but available through Medicare or Texas Medicaid.

Other services covered by Medicare or Texas Medicaid	Your costs
Some hospice care services	$0
Pre-admission screening and resident review (PASRR)	$0

E. Services not covered by Amerigroup STAR+PLUS MMP, Medicare, or Texas Medicaid

This is not a complete list. Call Member Services or read the *Member Handbook* to find out about other excluded services.

Services not covered by Amerigroup STAR+PLUS MMP, Medicare, or Texas Medicaid	
Private room	A private room in a hospital is not covered, except when it is medically needed.
Private duty nurses	Private duty nursing services provided in a hospital are not covered by our plan.
Cosmetic surgery	Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
Chiropractic care	Other than manual manipulation of the spine consistent with Medicare coverage guidelines or for an acute condition or an acute exacerbation of a chronic condition consistent with Texas Medicaid coverage guidelines.
Elective or voluntary enhancement procedures or services	Including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance, except when medically needed.

Services not covered by Amerigroup STAR+PLUS MMP, Medicare, or Texas Medicaid	
Naturopath services	Naturopath services (the use of natural or alternative treatments).
Services provided to veterans in Veterans Affairs (VA) facilities	When a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference.

F. Your rights as a member of the plan

As a member of Amerigroup STAR+PLUS MMP, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
  - Get information in other formats (e.g., large print, braille, audio)
  - Be free from any form of physical restraint or seclusion
  - Not be billed by network providers.
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a format you can understand. These rights include getting information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and care managers
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a Primary Care Provider (PCP) and change your PCP at any time during the year

- Use a women's health care provider without a referral
- Get your covered services and drugs quickly
- Know about all treatment options, no matter what they cost or whether they are covered
- Refuse treatment, even if your doctor advises against it
- Stop taking medicine
- Ask for a second opinion. Amerigroup STAR+PLUS MMP will pay for the cost of your second opinion visit.

- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act.
  - Have interpreters to help with communication with your doctors and your health plan.
- **You have the right to emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior approval in an emergency
  - Use an out-of-network, urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected.
  - Have your personal health information kept private.
- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - File a complaint or grievance against us or our providers
  - Ask for a state fair hearing
  - Get a detailed reason for why services were denied

For more information about your rights, you can read the Amerigroup STAR+PLUS MMP *Member Handbook*. If you have questions, you can also call Amerigroup STAR+PLUS MMP Member Services.

G. How to file a complaint or appeal a denied service

If you have a complaint or think Amerigroup STAR+PLUS MMP should cover something we denied, call Amerigroup STAR+PLUS MMP at **1-855-878-1784** (TTY: **711**). You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the Amerigroup STAR+PLUS MMP *Member Handbook*. You can also call Amerigroup STAR+PLUS MMP Member Services.

Or contact us by mail at:	Or contact us by fax at:
Amerigroup STAR+PLUS MMP Complaints, Appeals, and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, OH 45040	**For Part C (medical):** 1-888-458-1406 **For Part D (prescription drugs):** 1-888-458-1407

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at Amerigroup STAR+PLUS MMP Member Services. Phone numbers are on the cover of this summary.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste, or abuse, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or weren't necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Texas Medicaid ID.
- Using someone else's Texas Medicaid ID.
- Not telling the truth about the amount of money or resources they have to get benefits.

I. Ways to report fraud, waste, or abuse

- Call the OIG Hotline at 1-800-436-6184;
- Visit oig.hhsc.texas.gov/ and click "Report Fraud" to complete the online form; **or**
- You can report directly to your health plan:

  Amerigroup STAR+PLUS MMP

  5959 Corporate Drive, Suite 1300

  Houston, TX 77036; **and**

  1-855-878-1784 (TTY: 711)

I1. To report fraud, waste, or abuse, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.), include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Texas Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the fraud, waste, or abuse
- You may also report fraud by contacting the Texas Department of Insurance at 1-800-252-3439 or you may visit them online at http://www.tdi.texas.gov/fraud.

TEXAS Health and Human Services | TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice | Amerigroup

Have questions?
Call us toll-free at **1-855-878-1784** (TTY: **711**)
Monday through Friday from 8 a.m. to 8 p.m. local time.
Or visit **www.myamerigroup.com/TXmmp**.

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

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