TEXAS Health and Human Services

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

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2019 Member Handbook

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) *Member Handbook*

January 1, 2019 – December 31, 2019

Your Health and Drug Coverage under the Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan)

Member Handbook Introduction

This handbook tells you about your coverage under Amerigroup STAR+PLUS MMP through December 31, 2019. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports (LTSS). LTSS help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

This Amerigroup STAR+PLUS MMP plan is offered by Amerigroup Texas, Inc. (Amerigroup). When this *Member Handbook* says "we," "us," or "our," it means Amerigroup Texas, Inc. (Amerigroup). When it says "the plan" or "our plan," it means Amerigroup STAR+PLUS MMP.

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 make a standing request to get this and future information for free in other languages and formats. Call 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. The call is free.

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Disclaimers

- Amerigroup STAR+PLUS MMP is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.
- Coverage under Amerigroup STAR+PLUS MMP qualifies as minimum essential coverage (MEC). It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement for MEC.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Amerigroup STAR+PLUS MMP, a health plan that covers all your Medicare and Texas Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from 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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A. Welcome to Amerigroup STAR+PLUS MMP

Amerigroup STAR+PLUS MMP is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports (LTSS), and other providers. It also has service coordinators and service coordination teams to help you manage all your providers and services. They all work together to provide the care you need.

Amerigroup STAR+PLUS MMP was approved by the State of Texas and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Texas Dual Eligibles Integrated Care Demonstration Project.

The Texas Dual Eligibles Integrated Care Demonstration Project is a demonstration program jointly run by Texas and the federal government to provide better health care for people who have both Medicare and Texas Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Texas Medicaid health care services.

Amerigroup has served Texans since 1996. We live and work in your community and understand your unique health care needs. We're ready to put our experience to work for you and help you get the most out of the Amerigroup STAR+PLUS MMP program.

B. Information about Medicare and Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

B2. Texas Medicaid

Texas Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for LTSS and medical costs. It covers extra services and drugs not covered by Medicare.

Each state has its own Medicaid program and decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, and
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Texas must approve Amerigroup STAR+PLUS MMP each year. You can get Medicare and Texas Medicaid services through our plan as long as:

- you are eligible to participate in the Texas Dual Eligibles Integrated Care Demonstration Project;
- we offer the plan in your county, and
- Medicare and the State of Texas approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Texas Medicaid services will not change.

C. Advantages of this plan

You will now get all your covered Medicare and Texas Medicaid services from Amerigroup STAR+PLUS MMP, including prescription drugs. **You do not pay extra to join this health plan**.

Amerigroup STAR+PLUS MMP will help make your Medicare and Texas Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a service coordination team that you helped put together. Your service coordination team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a service coordinator. This is a person who works with you, with Amerigroup STAR+PLUS MMP, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your service coordination team and service coordinator.
- The service coordination team and service coordinator will work with you to come up with a Plan of Care specifically designed to meet your health needs. The service coordination team will be in charge of coordinating the services you need. This means, for example:
    - Your service coordination team will make sure your doctors know about all medicines you take so they can reduce any side effects.
    - Your service coordination team will make sure your test results are shared with all your doctors and other providers.

D. Amerigroup STAR+PLUS MMP's service area

Our service area includes these counties in Texas: *Bexar, El Paso, Harris, and Tarrant*.

Only people who live in one of these counties in our service area can get Amerigroup STAR+PLUS MMP.

If you move outside of our service area, you cannot stay in this plan. See Chapter 8, for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as:

- you are age 21 or older, **and**
- you live in our service area, **and**
- you have both Medicare Part A and Medicare Part B, **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are eligible for Texas Medicaid and **at least one** of the following:
    - have a physical disability or a mental disability and qualify for Supplemental Security Income (SSI), or
    - qualify for Texas Medicaid because you receive Home and Community Based Services (HCBS) waiver services; **and**
- you are NOT enrolled in one of the following 1915(c) waiver programs:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf Blind with Multiple Disabilities Program (DBMD)
    - Home and Community-based Services (HCS)
    - Texas Home Living Program (TxHmL)

F. What to expect when you first join a health plan

When you first join the plan, you will get a health risk assessment within the first 90 days.

The health risk assessment takes a deeper look at your medial needs, social needs and capabilities. We will gather information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified health professionals, such as clinical service coordinators, or community health workers.

If the results of your health risk assessment shows you have high health needs, you may be asked to complete additional assessments to determine whether you need additional care through Texas Medicaid's STAR+PLUS Waiver program.

If Amerigroup STAR+PLUS MMP is new for you, you can keep seeing the doctors you go to now for 90 days or until the new health risk assessment is finished.

After 90 days for most services, but six months for long-term services and supports (LTSS), you will need to see doctors and other providers in the Amerigroup STAR+PLUS MMP network. A network provider is a provider who works with the health plan. See Chapter 3 for more information on getting care.

G. Your Plan of Care

Your Plan of Care is the plan for what health services you will get and how you will get them.

After your health risk assessment, your service coordination team will meet with you to talk about what health services you need and want. Together, you and your service coordination team will make your Plan of Care.

Every year, your service coordination team will work with you to update your Plan of Care if the health services you need and want change.

Your Plan of Care is developed with you or your designated representative to help ensure your needs are met in the most appropriate setting. Your service coordinator will continue to work with you throughout the year to help ensure you are making progress toward meeting your goals and getting the services identified in your Plan of Care.

H. Amerigroup STAR+PLUS MMP monthly plan premium

Amerigroup STAR+PLUS MMP does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can also see the *Member Handbook* at www.myamerigroup.com/TXmmp or download it from this website.

The contract is in effect for the months you are enrolled in Amerigroup STAR+PLUS MMP between January 1, 2019 and December 31, 2019.

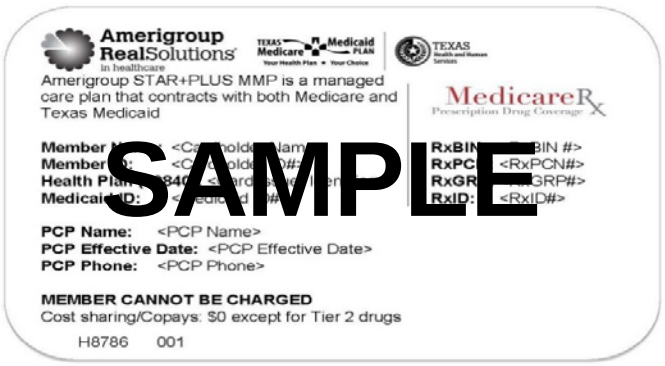
J. Other information you will get from us

You should have already gotten an Amerigroup STAR+PLUS MMP Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*.

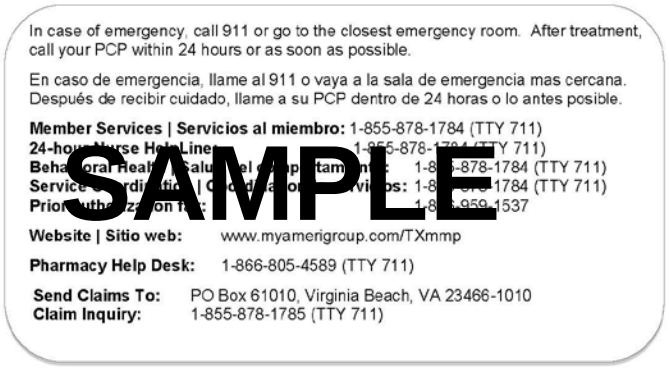
J1. Your Amerigroup STAR+PLUS MMP Member ID Card

Under our plan, you will have one card for your Medicare and Medicaid services, including long-term services and supports (LTSS) and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:

Front of Member ID Card



Back of Member ID Card



If your card is damaged, lost, or stolen, call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Texas Benefits Medicaid Card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Amerigroup STAR+PLUS MMP Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. See Chapter 7 to see what to do if you get a bill from a provider. The only exceptions are:

- If you need hospice care, then you will use your Original Medicare card, or
- If you need non-emergency transportation services, then you will use your Texas Benefits Medicaid Card.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Amerigroup STAR+PLUS MMP network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 8).

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can also see the *Provider and Pharmacy Directory* at www.myamerigroup.com/TXmmp or download it from this website.

The *Provider and Pharmacy Directory* also gives you the provider's address, phone number and office hours, if the provider is accepting new patients, if the location is accessible to people with disabilities, and if the provider has received cultural competency training.

Definition of network providers

- Network providers include:
  - Doctors, nurses, and other health care professionals that you can go to as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan and;
  - Home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Texas Medicaid.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time for more information. Both Member Services and Amerigroup STAR+PLUS MMP's website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Amerigroup STAR+PLUS MMP.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5 for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit www.myamerigroup.com/TXmmp or call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

J4. *The Explanation of Benefits*

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or EOB).

The *Explanation of Benefits* tells you the total amount you or others on your behalf have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Member Services.

K. How to keep your membership record up to date

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- Any liability claims, such as claims from an automobile accident
- Admission to a nursing home or hospital
- Care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become a part of a clinical research study

If any information changes, please let us know by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, see Chapter 8.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Amerigroup STAR+PLUS MMP and your health care benefits. You can also use this chapter to get information about how to contact your Service Coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. How to contact Amerigroup STAR+PLUS MMP Member Services

CALL	1-855-878-1784 This call is free. Monday through Friday from 8 a.m. to 8 p.m. local time, except for holidays If you need emergency services, please call 911. If you call on a holiday, Saturday or Sunday, you can leave a voicemail message. We will return your call within one (1) business day. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday through Friday from 8 a.m. to 8 p.m. local time
WRITE	Amerigroup STAR+PLUS MMP MMP Member Services 7430 Remcon Circle Building C, Suite 120 El Paso, TX 79912
WEBSITE	www.myamerigroup.com/TXmmp

A1. When to contact Member Services

- Questions about the plan
- Questions about claims, billing or Member ID Cards
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we will pay for your health services.
  - Call us if you have questions about a coverage decision about health care.
  - To learn more about coverage decisions, see Chapter 9.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
  - To learn more about making an appeal, see Chapter 9.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F below).
  - If your complaint is about a coverage decision about your health care, you can make an appeal (see the section above).
  - You can send a complaint about Amerigroup STAR+PLUS MMP right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, see Chapter 9.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs, **or**
    - the amount we will pay for your drugs.
  - This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, see Chapter 9.
- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.

To make an appeal about a Part D drug (formulary tiers 1 and 2), a non-Part D drug (formulary tiers 3 and 4), or a standard service or payment, submit your appeal within 60 days of the coverage decision by:

- Phone (Part D drugs, non-Part D drugs, standard service appeals only): 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time

- Mail (all appeals):

  Amerigroup STAR+PLUS MMP
  MMP Appeals and Grievances
  Mailstop OH0205-A537
  4361 Irwin Simpson Road
  Mason, OH 45040

- Fax (all appeals): 1-888-458-1406
- For more on making an appeal about your prescription drugs, see Chapter 9.

- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (See the section above.)
  - You can send a complaint about Amerigroup STAR+PLUS MMP right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, see Chapter 9.
- Payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, see Chapter 7.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9 for more on appeals.

B. How to contact your Service Coordinator

When you join, you will be assigned a clinical service coordinator who will help arrange care for all your needs: medical, behavioral health, community-based or facility-based Long-Term Services and Supports (LTSS), and social needs.

If you already have a service coordinator (from Amerigroup STAR+PLUS MMP, for example), you can ask for that person to be your Amerigroup STAR+PLUS MMP service coordinator. We'll OK your request as long as:

- That service coordinator is also available in Amerigroup STAR+PLUS MMP
- He or she has the time, based on current caseload

If you don't choose a service coordinator, we'll connect you with one. We'll choose one with the right experience and qualifications to care for your unique needs. You have the right to change your service coordinator at any time.

CALL	1-855-878-1784 This call is free. Monday through Friday from 8 a.m. to 5 p.m. local time We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday through Friday from 8 a.m. to 5 p.m. local time
WRITE	MMP Service Coordination 7430 Remcon Circle Building C, Suite 120 El Paso, TX 79912

B1. When to contact your Service Coordinator

- Questions about your health care
- Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)

The state and Amerigroup STAR+PLUS MMP determine your eligibility for LTSS services.

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

- Personal Assistance Services (PAS)
- Day Activity and Health Services (DAHS)
- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medical social services
- Home health care

C. How to contact the Nurse Advice Call Line

Sometimes you'll have health questions late at night, on the weekends or on holidays. We understand. No matter what day or time it is, you can talk to a registered nurse by calling our Nurse Advice Call Line.

CALL	1-855-878-1784 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week

C1. When to contact the Nurse Advice Call Line

- Questions about your health care

D. How to contact the Behavioral Health and Substance Abuse Crisis Line

CALL	1-855-878-1784 This call is free. The phone line is staffed by trained personnel 24 hours a day, 7 days a week. If you need emergency services, please call 911. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day/7 days a week

D1. When to contact the Behavioral Health and Substance Abuse Crisis Line

- Questions about behavioral health services
- Questions about substance abuse treatment services

E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP).

HICAP is not connected with any insurance company or health plan.

CALL	1-800-252-9240
WRITE	Texas Health and Human Services P.O. Box 13247 Austin, Texas 78711-3247
WEBSITE	http://www.tdi.texas.gov/consumer/hicap/

E1. When to contact HICAP

- Questions about your Medicare health insurance
  - HICAP counselors can answer your questions about changing to a new plan and help you:
    - understand your rights,
    - understand your plan choices,
    - make complaints about your health care or treatment, **and**
    - straighten out problems with your bills.

F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called KEPRO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with our plan.

CALL	1-888-315-0636
TTY	1-855-843-4776
WRITE	KEPRO 5201 W Kennedy Blvd. Suite 900 Tampa, FL 33609
WEBSITE	www.keproqio.com

F1. When to contact KEPRO, a Medicare Quality Improvement Organization

- Questions about your health care
  - You can make a complaint about the care you got if you:
    - have a problem with the quality of care,
    - think your hospital stay is ending too soon, **or**
    - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Forms, Help & Resources" and then clicking on "Phone numbers & websites." The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Texas Medicaid

Texas Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Texas Medicaid.

CALL	1-800-252-8263 or 2-1-1
TTY	1-800-735-2989 or 7-1-1
WRITE	Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316
WEBSITE	http://yourtexasbenefits.hhsc.state.tx.us/

I. How to contact the HHSC Office of the Ombudsman

The HHSC Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The HHSC Office of the Ombudsman also helps people enrolled in Texas Medicaid with service or billing problems. They are not connected with our plan or with any insurance company or health plan. The HHSC Office of the Ombudsman is an independent program, and their services are free.

CALL	1-866-566-8989
TTY	1-800-735-2989 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Texas Health and Human Services Commission Office of the Ombudsman, MC H-700 P O Box 13247 Austin, TX 78711-3247
WEBSITE	http://www.hhsc.state.tx.us/ombudsman/

J. How to contact the Texas Long-Term Care Ombudsman

The Texas Long-Term Care Ombudsman is an ombudsman program that helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and residents or their families.

CALL	1-800-252-2412
WRITE	Texas Long-Term Care Ombudsman Program Texas Health and Human Services P. O. Box 149030 MC-W250 Austin, TX 78714-9030
EMAIL	ltc.ombudsman@hhsc.state.tx.us
WEBSITE	https://apps.hhs.texas.gov/news_info/ombudsman/

K. Other resources

- **2-1-1** Texas, a program of the Texas Health and Human Services Commission, is committed to helping Texas citizens connect with the services they need.
  - » Dial 211 or 1-877-541-7905
  - » www.211texas.org/

Chapter 3: Using the plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Amerigroup STAR+PLUS MMP. It also tells you about your Service Coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Information about "services," "covered services," "providers," and "network providers"

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4.

Providers are doctors, nurses, and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

Amerigroup STAR+PLUS MMP covers all services covered by Medicare and Texas Medicaid. This includes behavioral health and long-term services and supports (LTSS).

Amerigroup STAR+PLUS MMP will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4 of this handbook.)
- The care must be **medically necessary.** Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart. When we give our decision, we base it on two things. First there are Medicare's rules. Second there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for Urgent care, Emergency care or Renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Member Services. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

- In most cases, our plan must give you approval before you can see someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Amerigroup STAR+PLUS MMP may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. To learn more about referrals, see page 33.
- You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 33.
- To learn more about choosing a PCP, see page 32.
- **Note:** In your first 90 days with our plan, you may continue to see your current providers, at no cost, if they are not a part of our network. During the 90 days, our Service Coordinator will contact you to help you find providers in our network. After 90 days, we will no longer cover your care if you continue to see out-of-network providers.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what emergency or urgently needed care means, see Section I, page 37.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to see an out-of-network provider, see Section D, page 31.
  - The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - When you first join the plan, you can continue seeing the providers you see now for at least 90 days.

C. Information about your Service Coordinator

C1. What a Service Coordinator is

The Amerigroup STAR+PLUS MMP service coordinator makes sure all your care and services work together. The service coordinator will ensure the integration of your medical, behavioral health, substance use, community-based or facility-based long-term services and supports (LTSS), and social needs. The service coordinator will coordinate these services as specified in your personal care plan.

C2. How you can contact your Service Coordinator

When a service coordinator is assigned or selected, Amerigroup STAR+PLUS MMP will provide you with contact information for your service coordinator. Member Services can also provide this information to you at any time during your participation in Amerigroup STAR+PLUS MMP.

C3. How you can change your Service Coordinator

You may change your service coordinator at any time, but you will have to choose from a list of Amerigroup STAR+PLUS MMP service coordinators. If the service coordinator is also available in the Amerigroup STAR+PLUS MMP and the service coordinator's caseload permits, Amerigroup STAR+PLUS MMP must honor your request. To change service coordinators, contact Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

C4. What a Service Coordinator can do for you

The state sends us information about your health and the services you have been getting from Medicare and Texas Medicaid. Your service coordinator will read this information to find out more about you. It will tell them which providers they need to call to be sure you keep getting the right care. We will ask you how helpful your Medicare and Texas Medicaid services have been. We will talk to your Medicare and Texas Medicaid providers about the care you have been getting and, if you agree, we will talk to your doctors about your health-care needs.

D. Care from primary care providers, specialists, other network providers, out-of-network providers, and how to change health plans

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of "PCP," and what a PCP does for you

Your primary care provider (PCP) is your main doctor and will be responsible for providing many of your preventive and primary care services. Your PCP will help create your personal care plan and will recommend or ask for many of the services you'll get through your health plan.

Your PCP can be one of the following providers, or under certain circumstances such as pregnancy, a specialist:

- Family practice
- Internal medicine
- General practice
- OB/GYN
- Geriatrics
- Pediatricians
- Certified Nurse Practitioner (CNP), and Physician Assistant (PA)
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

Your choice of PCP

You can choose a PCP from our list of providers in our online (website) provider directory. If your doctor is not in our directory, nothing has to change for 90 days. During that time, we will work to include your doctor in our network.

If you do not choose a PCP within 90 days, one will be assigned to you. You can change your PCP at any time by contacting Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

We will give you a choice of at least three PCPs when you call Member Services. If you don't choose a PCP, we will assign one to you. In finding the right PCP for you, we will look at how far the PCP is from your home, any special health care needs you have, and the language you speak.

If you already have a PCP when you join the plan, you can keep seeing that PCP during the transition period. After the transition period, you can keep that PCP if he or she is in our network.

Option to change your PCP

You may change your PCP for any reason, at any time during the year. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP if the one you have now leaves our network.

Simply call Member Services and ask for a new PCP. The plan will put your request in the system and tell you when your PCP change will take effect. Requests made on the 15th day of the month or earlier will be effective on the first of the current month. Requests made on the 16th of the month or later will be effective on the first of the following month.

If your PCP leaves our network or otherwise becomes unavailable, Amerigroup STAR+PLUS MMP will give you the chance to choose a new PCP.

Services you can get without first getting approval from your PCP

In most cases, you will need approval from your PCP before seeing other providers. This approval is called a referral. You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to network providers (for example, when you are outside the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Any Behavioral Health Services Network Provider without a referral from your PCP.
- Sexually Transmitted Disease (STD) services that include STD/HIV prevention, screening, counseling, diagnosis and treatment.
- Network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery.
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.

- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

If you need care from a specialist or other network provider, your PCP will refer you to the specialist or other network provider. Your choice of PCP will not limit your choice of specialist or other network provider.

Prior authorization means you have to get approval from the health plan before you see a specialist or get specific services or drugs. A licensed clinical person, like a doctor or nurse practitioner, will look at coverage rules to determine medical need. This prior approval is based on information we get from your PCP and specialists, your medical history and/or how severe your illness is. Your physician or health care provider is responsible for asking for prior approval before giving you any treatments or services that prior authorization is required for. See the Benefits Chart in Chapter 4 for information about which services require prior authorization.

D3. What to do when a provider leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask for, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

D4. How to get care from out-of-network providers

If you need care that our plan covers and our network providers cannot give it to you, you can get permission from Amerigroup STAR+PLUS MMP to get the care from an out-of-network provider. If this happens, we will cover the care as if you got it from a network provider and at no cost to you. To

ask for approval to see an out-of-network provider, you or your representative may call your service coordinator. If your service coordinator is not available, you may call Member Services.

Remember, when you first join the plan, you can keep seeing the providers you see now during the transition period. In most cases, the transition period will last for 90 days or until your personal care plan is finalized and implemented, whichever is later. During the transition period, our service coordinator will contact you to help you find and switch to providers that are in our network. After the transition period, we will no longer pay for your care if you continue to see out-of-network providers, unless Amerigroup STAR+PLUS MMP gives you the OK to keep seeing the out-of-network provider.

If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Texas Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Texas Medicaid.
- If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

D5. How to change health plans

You can change your health plan. For more information, see Chapter 10, Section A. You can also get help from the following resources:

- Call Maximus at 1-877-782-6440, from 8 a.m. to 6 p.m., Monday through Friday. TTY users should call 711.
- Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

E. How to get long-term services and supports (LTSS)

Community-based LTSS are a range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health. These services are provided in the person's home or a community-based setting such as assisted-living facilities. Facility-based LTSS are services provided in a nursing facility or other long-term residential care setting.

As a member in Amerigroup STAR+PLUS MMP, you will receive a comprehensive assessment of your needs, including your need for community-based or facility-based LTSS.

All of your needs, as identified in your assessment, will be addressed in your personal care plan. Your personal care plan will outline which LTSS you will get, from whom, and how often.

If you have a pre-existing service plan prior to your enrollment into Amerigroup STAR+PLUS MMP, you will continue to receive any community-based or facility-based LTSS included in the pre-existing plan. Your pre-existing service plan will be honored for 90 days for medical and rehabilitation or 180 days for habitation, social services and long-term support services or until your personal care plan is finalized and implemented, whichever is later.

If you have questions about LTSS, contact Member Services or your service coordinator.

F. How to get behavioral health services

Behavioral health services are a variety of services that can support mental health and substance abuse needs you may have. This support can include emotional, social, educational, vocational, peer support, and recovery services, in addition to more traditional psychiatric or medical services.

As a member in Amerigroup STAR+PLUS MMP, you will receive a comprehensive assessment of your needs, including your need for behavioral health services. All of your needs, as identified in your assessment, will be addressed in your personal care plan. Your personal care plan will outline which behavioral health services you will get, from whom, and how often.

If you are receiving services from a behavioral health provider at the time of your enrollment in Amerigroup STAR+PLUS MMP, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in Amerigroup STAR+PLUS MMP's network.

If you have questions about behavioral health services, contact Member Services or your service coordinator.

G. How to get self-directed care

G1. What self-directed care is

Self-directed care, also called self-direction or Consumer Directed Services, means you can hire, fire and supervise your own service providers. For this program, you can self-direct your Respite Care, Personal Assistance Services, Habilitation, Nursing Services and Therapies.

G2. Who can get self-directed care (for example, if it is limited to waiver populations)

During your first health assessment, your service coordinator will help you decide whether this is the right choice for you. If you choose to self-direct your care, we will help you understand your responsibilities.

G3. How to get help in employing personal care providers (if applicable)

If you choose a self-directed care option, you will select the Consumer Directed Services Agency (CDSA) to assist with your payroll and act as your agent to pay federal and state taxes; assist you with a budget and guidance on recruitment, wages, benefits and administrative costs.

H. How to get transportation services

The Medical Transportation Program (MTP) provides non-ambulance transportation to and from covered medical services. Transportation is provided to members and attendants when they have no other means of transportation and based on medical necessity.

Transportation for dental care is available for STAR+PLUS Waiver members only. MTP does not provide transportation to dental services that are available from the plan as an extra or flexible benefit.

To arrange MTP transportation:

Call 1-877-633-8747, Monday through Friday, from 8 a.m. to 5 p.m. local time. Calls to this number are free. You will need to provide your STAR+PLUS ID Card number and your home ZIP code.

All requests for transportation services should be made within 2-5 days of your appointment. Exceptions may be given in an emergency.

I. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

I1. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
  - there is not enough time to safely transfer you to another hospital before delivery.

- a transfer to another hospital may pose a threat to your health or safety of that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

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

- **Tell Amerigroup STAR+PLUS MMP about your emergency as soon as possible.** We need to follow up on your emergency care. You or your service coordinator should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

Definition of post-stabilization

Post-stabilization care services are services that keep your condition stable following emergency medical care.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What to do if you have a behavioral health emergency

Dial 1-855-878-1784 and press option 9 for behavioral health emergency.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was not an emergency, we will cover your additional care only if:

- you go to a network provider, **or**

- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

I2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

To find an urgent care center:

- Look in our *Provider and Pharmacy Directory* online at www.myamerigroup.com/TXmmp.
- Call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider. Our plan does not cover urgently needed care or any other care that you get outside the United States.

I3. Care during a disaster

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

Please visit our website for information on how to obtain needed care during a declared disaster: www.myamerigroup.com/TXmmp.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

J. What to do if you are billed directly for services covered by our plan

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid for your covered services or if you have gotten a bill for covered medical services, see Chapter 7 to learn what to do.

J1. What to do if services are not covered by our plan

Amerigroup STAR+PLUS MMP covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (see Chapter 4), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

K. Coverage of health care services when you are in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers.

You do need to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your Service Coordinator should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

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

If you are part of a study that Medicare has **not approved**, you will have to pay any costs for being in the study.

K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (https://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

L. How your health care services are covered when you get care in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

L2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is any care that is not voluntary and is required under federal, state, or local law.

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.
  - Coverage limitations apply; see the Benefits Chart in Chapter 4 for more information.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME means certain items ordered by a provider for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics

In this section, we discuss DME you must rent. As a member of Amerigroup STAR+PLUS MMP, you will not own DME, no matter how long you rent it.

In certain situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

Our plan will pay for some durable medical equipment (DME) and products normally found in a pharmacy. Amerigroup STAR+PLUS MMP pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. Call Member Services for more information about these benefits.

M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2019* Handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov/) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage Plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or a Medicare Advantage plan.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Amerigroup STAR+PLUS MMP covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you what services Amerigroup STAR+PLUS MMP pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

Because you get assistance from Texas Medicaid, you pay nothing for your covered services as long as you follow the plan's rules. See Chapter 3 for details about the plan's rules.

If you need help understanding what services are covered, call your Service Coordinator and/or Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

B. Rules against providers charging you for services

We do not allow Amerigroup STAR+PLUS MMP providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, see Chapter 7 or call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

C. Our plan's Benefits Chart

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Texas Medicaid covered services must be provided according to the rules set by Medicare and Texas Medicaid.
    - The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart. When we give our decision, we base it on two things. First there are Medicare's rules. Second there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need

it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for Urgent care, Emergency care or Renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Member Services. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You see your primary care provider (PCP) first for most of your regular health care needs. Your PCP, along with your service coordinator, can help plan and schedule your covered services. This includes X-rays, laboratory tests, home health services, therapies, care from specialists, hospital admissions, and follow-up care. Your PCP also contacts other plan providers for updates about your care and/or treatments.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can see someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3 has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization are marked in the Benefits Chart in bold type.
- All preventive services are free. You will see this apple 🍎 next to preventive services in the Benefits Chart.

D. The Benefits Chart

		What you must pay
	Abdominal aortic aneurysm screening The plan will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Acupuncture The plan will pay for up to six (6) visits for acupuncture services per year. **Prior authorization may be required.**	$0
	Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0
	Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0

Services that our plan pays for		What you must pay
	Annual wellness visit If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	$0
	Behavioral health services The plan will pay for the following services: • Mental health targeted case management • Mental health rehabilitative services **Prior authorization may be required**	$0
	Bone mass measurement The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will pay for the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) The plan will pay for the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	$0

Services that our plan pays for		What you must pay
	Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. In addition to the covered service, the plan offers up to 12 additional visits per year. **Prior authorization may be required**	$0
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, or • give you tips to make sure you are eating well.	$0
	Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0
	Cervical and vaginal cancer screening The plan will pay for the following services: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	$0

Services that our plan pays for		What you must pay
	Chiropractic services The plan will pay for the following services: • Adjustments of the spine to correct alignment	$0
	Colorectal cancer screening For people 50 and older, the plan will pay for the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).	$0

Services that our plan pays for		What you must pay
	Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. The plan also offers tobacco cessation counseling for pregnant women. **Referral required.**	$0
	Dental services Amerigroup STAR+PLUS MMP will pay for the following services: *Preventive dental services* • Oral exam, 2 every year • Cleaning, 2 every year • Dental x-ray, 1 every year *Comprehensive dental services* Additional dental benefits include dental services limited to $625 every three (3) months. Unused quarterly allowance carries over to the next quarter, but does not carry over to the next year. Benefit resets to $0 January 1st of each year. **Nonroutine, diagnostic, restorative, endodontic, periodontic, and extraction services require prior authorization and a referral.**	$0

Services that our plan pays for		What you must pay
	Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.	$0
	Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months	$0

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: o A blood glucose monitor o Blood glucose test strips o Lancet devices and lancets o Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: o One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** o One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. • The plan will pay for training to help you manage your diabetes, in some cases.	$0

Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (For a definition of "Durable medical equipment (DME)," see Chapter 12 of this handbook.) The following items are covered: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers Other items may be covered. We will pay for all medically necessary DME that Medicare and Texas Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health, or to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part; **or** • in the case of a pregnant woman in active labor, when: o there is not enough time to safely transfer you to another hospital before delivery. o a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Medical services performed out of the country are not covered.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.

Services that our plan pays for		What you must pay
	Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will pay for the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling The plan will also pay for some other family planning services. However, you must see a provider in the plan's network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing **Prior authorization may be required**	$0

Services that our plan pays for		What you must pay
	Health and wellness education programs We offer programs to help you manage chronic conditions and identified health conditions, including: ▪ Health education ▪ Fitness benefit ▪ Enhanced disease management ▪ 24-hour Nurse HelpLine ▪ Counseling services	$0
	Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. The plan covers Texas Medicaid's hearing aid benefit of one hearing aid, left or right ear, every five years (limitations apply). In addition to the covered benefit, the plan offers up to two (2) hearing aids every year with a fitting and evaluation as needed. Hearing aid coverage is limited to $2,000 every year (both ears combined). **Prior authorization may be required.**	$0
	HIV screening The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0

Services that our plan pays for		What you must pay
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior authorization may be required.**	$0
	Hospice care You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal prognosis and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Hospice care (continued) **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • See Section F of this chapter for more information. **For services covered by Amerigroup STAR+PLUS MMP but not covered by Medicare Part A or B:** • Amerigroup STAR+PLUS MMP will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by Amerigroup STAR+PLUS MMP's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5. **Note:** If you need non-hospice care, you should call your service coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	$0
	Immunizations The plan will pay for the following services: • Pneumonia vaccine • Flu shots, once a year, in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more.	$0

Services that our plan pays for		What you must pay
	Inpatient hospital care The plan will pay for the following services, and maybe other services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Inpatient hospital care (continued) • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • Blood, including storage and administration o The plan will pay for whole blood and packed red cells beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else o The plan will pay for all other parts of blood beginning with the first pint used. • Physician services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If Amerigroup STAR+PLUS MMP provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. The plan offers thirty (30) additional days per benefit period. **Prior authorization may be required.**	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

Services that our plan pays for		What you must pay
	Inpatient mental health care • The plan will pay for mental health care services that require a hospital stay. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • Limitations may apply. • The plan offers unlimited additional psychiatric inpatient days per benefit period**.** **Prior authorization may be required.**	$0
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If your inpatient stay is not reasonable and necessary, the plan will not pay for it. However, in some cases the plan will pay for services you get while you are in the hospital or a nursing facility. The plan will pay for the following services, and maybe other services not listed here: • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Inpatient services covered during a non-covered inpatient stay (continued) • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: o replace all or part of an internal body organ (including contiguous tissue), or o replace all or part of the function of an inoperative or malfunctioning internal body organ. • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition • Physical therapy, speech therapy, and occupational therapy	$0

Services that our plan pays for		What you must pay
	Kidney disease services and supplies The plan will pay for the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 • Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Prior authorization may be required** Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.	$0

Services that our plan pays for		What you must pay
	Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • Are aged 55-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.	$0

Services that our plan pays for		What you must pay
	Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Amerigroup STAR+PLUS MMP will pay for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued) Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 explains what you pay for your outpatient prescription drugs through our plan**.** **Prior authorization may be required.**	
	Nursing facility care The plan will pay for the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration ▪ The plan will pay for whole blood, packed red cells, and all other parts of blood beginning with the first pint used ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Appliances, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services ▪ You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network: **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Nursing facility care (continued) o A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) o A nursing facility where your spouse lives at the time you leave the hospital o The nursing home where you were living when you enrolled in Amerigroup STAR+PLUS MMP **Prior authorization may be required.**	
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0

Services that our plan pays for		What you must pay
	Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, including storage and administration beginning with the fourth pint of blood that you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. The plan will pay for storage and administration beginning with the first pint of blood you need. • Other outpatient diagnostic tests	$0

Services that our plan pays for		What you must pay
	Outpatient hospital services The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services, and maybe other services not listed here: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself **Prior authorization may be required**	$0

Services that our plan pays for		What you must pay
	Outpatient mental health care The plan will pay for mental health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner, • a physician assistant, **or** • any other Medicare-qualified mental health care professional as allowed under applicable state laws. The plan will pay for the following services, and maybe other services not listed here: • Clinic services • Day treatment • Psychosocial rehab services **Prior authorization may be required.**	$0
	Outpatient rehabilitation services The plan will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Outpatient substance abuse services The plan will pay for the following substance abuse treatment services when medically necessary: ▪ **Outpatient substance abuse treatment services** – Includes assessment, evaluation, and medication management. Also includes individual, family, and group counseling. ▪ **Substance abuse crisis intervention** – Provides immediate substance abuse care to assist individuals who are experiencing acute dysfunction that needs immediate clinical attention. Services are available 24 hours a day, seven days a week. This service is meant to prevent your condition from getting worse, prevent injury to you or others, and provide treatment in the least restrictive setting. ▪ **Day treatment for pregnant women** – Substance abuse treatment services provided in a central location during the day for women who are pregnant or recently had a baby. Services include comprehensive and intensive intervention services. These services are meant to improve your pregnancy outcome, treat your substance abuse disorder, strengthen your relationship with the baby and any other children you have, and help you achieve and maintain a sober and drug-free lifestyle. **Prior authorization may be required.**	$0
	Outpatient surgery The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Over-the-counter (OTC) medications and items The plan covers a $102 allowance, every three months for plan-approved over-the-counter (OTC) health and wellness items. Any unused allowance does not carry over to the next quarter. This additional service does not require prior authorization or a prescription. The plan also covers Texas Medicaid's over-the-counter (OTC) medications and items when they are written as prescriptions by your provider. Please visit our website for Amerigroup STAR+PLUS MMP's List of Covered Drugs (Drug List) for more information. There may be limitations on the types of drugs covered.	$0
	Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Personal Assistance Services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Grooming • Eating • Bathing • Dressing and personal hygiene • Functional living tasks / assistance with planning • Preparing meals • Transportation, or assistance in securing transportation • Assistance with ambulation and mobility • Reinforcement of behavioral support or specialized therapies activities; and • Assistance with medications These services can be self-directed if you choose. This option allows you or your legally authorized representative to be the employer of some of your service providers and to direct the delivery of program services. **Prior authorization may be required.**	$0
	Personal Emergency Response System (PERS) The plan offers a personal monitoring system that works 24/7. In the event of an emergency, you can press a call button to signal for help. PERS is available to all members residing in the community (non-nursing facility members). Limitations and restrictions may apply. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Pest control The plan offers pest control treatments once every 3 months to eliminate rodents, roaches and other unsafe pests from the home. This extra benefit is limited to members residing in the community (non-nursing facility members). Limitations and restrictions may apply. **Prior authorization may be required.**	$0
	Physician/provider services, including doctor's office visits The plan will pay for the following services: • Medically necessary health care or surgery services given in places such as: o physician's office o certified ambulatory surgical center o hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider ***or*** specialist, if your doctor orders it to see whether you need treatment • Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare • Second opinion by another network provider before a medical procedure • Non-routine dental care. Covered services are limited to: o surgery of the jaw or related structures, o setting fractures of the jaw or facial bones, o pulling teeth before radiation treatments of neoplastic cancer, **or** o services that would be covered when provided by a physician. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Podiatry services The plan will pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes **Prior authorization may be required.**	$0
	Prostate cancer screening exams For men age 50 and older, the plan will pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See “Vision care” later in this section for details. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Pulmonary rehabilitation services The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD. **Prior authorization may be required.**	$0
	Sexually transmitted infections (STIs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care No prior hospital stay required. The plan will pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration o The plan will pay for whole blood and packed red cells beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. o The plan will pay for all other parts of blood beginning with the first pint used. • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Skilled nursing facility care (SNF) (continued) You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse lives at the time you leave the hospital **Prior authorization may be required.**	
	Supervised Exercise Therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider **The SET program must be:** • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0

Services that our plan pays for		What you must pay
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. Medical services performed out of the country are not covered.	$0
	Vision care The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Medicare does not cover regular eye exams for glasses or contacts. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes • African-Americans who are age 50 and older, and • Hispanic Americans who are 65 or older. The plan covers one eye exam every year. The plan will also pay for corrective lenses, frames and replacements if you need them after a cataract removal without a lens implant. In addition to the covered services, the plan will provide up to $300 extra for one (1) pair of frames, eyeglass lenses or contacts every year. **Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), and • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. Our home and community based services

In addition to these general services, our plan also covers home and community-based services. These are services that you may be able to use instead of going to a facility. To get some of these services, you will need to qualify for the home and community-based waiver (the STAR+PLUS Waiver). Your service coordinator will work with you to decide if these services are right for you and will be in your Plan of Care.

Community-based services that our plan covers	What you must pay
Adaptive Aids and Medical Supplies The plan covers the following devices, controls, appliances, or items that are necessary to address your specific needs, including those necessary for life support up to a $10,000 per year limit. The plan may pay for the following if medically or functionally necessary, and maybe other items/services not listed here: • Lifts, including vehicle lifts • Mobility Aids • Positioning Devices • Control switches/pneumatic switches and devices • Environmental control units • Medically necessary supplies • Communication aids (including batteries) • Adaptive/modified equipment for activities of daily living • Safety restraints and safety devices Case managers can help you get medical supplies or equipment. **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Adult Foster Care The plan covers 24-hour living arrangements in a foster home if you have physical, mental, or emotional limitations or if you are unable to continue functioning independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Meal preparation • Housekeeping • Personal care • Nursing tasks • Supervision • Companion services • Daily living assistance • Transportation **Prior authorization may be required.**	$0
Alzheimer's Care We offer a memory album of photos for members with memory loss to encourage memory retention. Photo albums may help to stimulate memories for a member suffering from Alzheimer's and other dementia. One photo album per lifetime. Must be diagnosed with Alzheimer's disease or other dementia. **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Assisted Living Services The plan covers a 24-hour living arrangement for you if you are unable to live independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Host home/companion care that provides you with: o Personal assistance o Functional living tasks o Supervision of your safety and security o Habilitation activities • Supervised living that provides you with: o Personal assistance o Functional living tasks o Supervision of your safety and security o Habilitation activities • Residential support service that provides you with: o Personal assistance o Functional living tasks **Prior authorization may be required.**	$0
Cognitive Rehabilitation Therapy The plan covers services that help you learn or re-learn cognitive skills. These skills may have been lost or altered as a result of damage to brain cells or brain chemistry. **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Day Activity Health and Services (DAHS) Adult day care provides social activities, meals, recreation, and some health-related services. Day health services offer more intensive health, therapeutic, and social services for individuals with severe medical problems and for those at risk of nursing home care. Alzheimer's specific adult day care provides social and health services only to persons with Alzheimer's or related dementia. **Prior authorization may be required.**	$0
Day Habilitation Services These services help you with obtaining, retaining, or improving skills necessary to live successfully at home and/or in community-based settings. They promote independence, personal choice, and achievement of the outcomes identified in your service plan. **Prior authorization may be required.**	$0
Dental Services The plan covers the following services to help preserve your teeth and meet your medical needs up to $5,000 per year. If the services of an oral surgeon are required, you can get an additional $5,000 per year. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Emergency dental treatment • Preventive dental treatment • Therapeutic dental treatment (restoration, maintenance, etc.) • Orthodontic dental treatment **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Emergency Response Services The plan covers emergency response services for you through an electronic monitoring system 24 hours a day, seven days a week. In an emergency, you can press a call button to signal for help. **Prior authorization may be required.**	$0
Employment Assistance The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Identifying your employment preferences, job skills, and requirements for a work setting and work conditions • Locating prospective employers offering employment compatible with your identified preferences, skills, and requirements; • Contacting a prospective employer on your behalf and negotiating your employment • Transportation • Participating in service planning team meetings	$0
Functional Living Task Services These services help you with: • Planning and preparing meals • Transportation, or help in securing transportation • Assistance with ambulation and mobility • Reinforcement of behavioral support or specialized therapies activities • Assistance with medications	$0

Community-based services that our plan covers	What you must pay
Home-Delivered Meals The plan covers hot, nutritious meals that are served in your home. Meals are limited to 1 to 2 per day. Additionally, for community well members, the plan covers hot, nutritious meals that are served in your home after you are discharged from a hospital or skilled nursing facility. Meals are limited to twice a day for five (5) days. Members in nursing facilities do not receive home-delivered meals. **Prior authorization may be required.**	$0
Minor Home Modifications The plan covers minor home modifications to ensure your health, welfare, and safety and to allow you to function with greater independence in your home. The plan will cover up to $7,500 over the course of your lifetime and will also cover up to $300 each year for repairs. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Installation of ramps and grab bars • Widening of doorways • Modifications of kitchen and bathroom facilities, and • Other specialized accessibility adaptations **Prior authorization may be required.**	$0
Nursing Services The plan covers the treatment and monitoring of your medical conditions, especially if you have chronic conditions that require specific nursing tasks. **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Occupational Therapy The plan covers occupational therapy for you, which provides assessment and treatment by a licensed occupational therapist. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Screening and assessment • Development of therapeutic treatment plans • Direct therapeutic intervention • Assistance, and training with adaptive aids and augmentative communication devices • Consulting with and training other service providers and family members • Participating on the service planning team, when appropriate **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Personal Assistance Services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Grooming • Eating • Bathing • Dressing and personal hygiene • Functional living tasks / assistance with planning • Preparing meals • Transportation or assistance in securing transportation • Assistance with ambulation and mobility • Reinforcement of behavioral support or specialized therapies activities; and • Assistance with medications **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Physical Therapy The plan covers physical therapy, assessments, and treatments by a licensed physical therapist. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Screening and assessment • Development of therapeutic treatment plans • Direct therapeutic intervention • Assistance and training with adaptive aids/augmentative communication devices • Consulting with and training other service providers and family members • Participating on the service planning team, when appropriate **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Respite Care The plan may pay for the following services if medically or functionally necessary up to 30 visits a year, and maybe other services not listed here: • Personal assistance • Habilitation activities • Community activities • Leisure activities • Supervision of your safety and security • Development of socially valued behaviors • Development of daily living skills Respite care is provided to ensure your comfort, health, and safety. It may be provided in the following locations: your home or place of residence; adult foster care home; Texas Medicaid certified nursing facility; and an assisted living facility. Non-waivered members who reside in the community are eligible receive a respite, which is limited to four (4) hours for two (2) days or eight (8) hours for one (1) day. **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Speech, Hearing, and Language Therapy The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Screening and assessment • Development of therapeutic treatment plans • Direct therapeutic intervention • Assistance/training with adaptive aids and augmentative communication devices • Consulting with and training other service providers and family members • Participating on the service planning team, when appropriate **Prior authorization may be required.**	$0
Support Consultation The plan covers optional support consultation provided by a chosen certified support advisor. This advisor will assist you in learning about and performing employer responsibilities. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Recruiting, screening, and hiring workers • Preparing job descriptions • Verifying employment eligibility and qualifications, and other documents required to employ an individual • Managing workers • Other professional skills as needed **Prior authorization may be required.**	$0

Community-based services that our plan covers	What you must pay
Supported Employment The plan covers supported employment, which is provided to you at your place of employment if: • You need the support services to maintain employment due to a disability; • You are paid minimum wage (or more) for the work performed; and • Your place of employment is competitive and integrated. The plan also covers transportation to and from your worksite, and supervision and training to you beyond what an employer would ordinarily provide. **Prior authorization may be required.**	$0
Transitional Assistance Services The plan covers one transition from a nursing facility to a home in the community, up to a $2,500 limit. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Payment of security deposits required to lease an apartment or home • Set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water • Purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens • Payment of moving expenses required to move into or occupy the home or apartment; and • Payment for services to ensure your health in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy **Prior authorization may be required.**	$0

F. Benefits covered outside of Amerigroup STAR+PLUS MMP

The following services are not covered by Amerigroup STAR+PLUS MMP but are available to you through Medicare or Texas Medicaid.

F1. Hospice Care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Hospice programs provide members and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Your hospice doctor can be a network provider or an out-of-network provider.

See the Benefits Chart in Section D of this chapter for more information about what Amerigroup STAR+PLUS MMP pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services and any Medicare Part A or B services. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by Amerigroup STAR+PLUS MMP's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5.

Note: If you need non-hospice care, you should call your service coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. local time for help with service coordination.

F2. Nonemergency Medical Transportation Services

These are transportation services to get you to medical appointments, like the doctor, dentist or drug store.

F3. Pre-Admission Screening and Resident Review (PASRR)

This is a program to ensure members are not inappropriately placed in nursing homes. This requires that members (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) get the services they need in those settings.

G. Benefits not covered by Amerigroup STAR+PLUS MMP, Medicare, or Texas Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not pay for these benefits. Medicare and Texas Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Texas Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3, pages 40-41, for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Homemaker services, including basic household assistance, light cleaning or making meals.

- 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 necessary.
- 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.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, 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. Members are still responsible for their cost sharing amounts.

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and some prescription and over-the-counter drugs covered under Texas Medicaid. Chapter 6 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Amerigroup STAR+PLUS MMP also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, certain home health supply products (test strips, lancets, spacers) and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
    - If it is not on the Drug List, we may be able to cover it by giving you an exception.
    - See Chapter 9 to learn about asking for an exception.
4. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books. A medically-accepted indication refers to the diagnosis or condition for which a drug is being prescribed, not the dose being prescribed for such indication. The drug must be used for a medically-accepted indication that

supports the diagnosis or treatment of illness or injury, or to improve the function of the body (except for Part D vaccines, which may be used for prevention of a condition).

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions only if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your service coordinator.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for our share of the cost of your covered prescription drug. You will need to pay the pharmacy a copay when you pick up your prescription.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

In some cases, **if the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up**. You can then ask us to pay you back for our share. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, see Chapter 7.
- If you need help getting a prescription filled, you can contact Member Services or your service coordinator.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

If you need help changing your network pharmacy, you can contact Member Services or your service coordinator.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your service coordinator.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
    - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
        - If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your service coordinator.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.

Our plan's mail-order service allows you to order up to a 93-day supply. A 93-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, visit our website at www.myamerigroup.com/TXmmp or call Member Services or your service coordinator.

Usually, a mail-order prescription will get to you within 7-14 days. If your mail-order prescription is delayed, we will cover a temporary supply from a retail pharmacy. Contact your service coordinator or Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

Mail-order processes

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy gets from you**

    The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. New prescriptions the pharmacy gets directly from your provider's office

After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time.

- This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped.
- It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail order refills, please contact us by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Let your service coordinator know, or call Member Services and we will update your member file. If we don't know the best way to reach you, you might miss the chance to tell us whether you want a refill, and you could run out of your prescription drugs.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 93-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you are travelling outside the service area, run out of your drug and can't get to a network pharmacy
- If you can't get a drug in a timely manner because there isn't a network pharmacy within driving distance that offers 24/7 service
- If the drug you take is not regularly stocked at an accessible pharmacy or mail-order pharmacy
- If the drug is given to you while you're in an emergency room, out-of-network hospital or facility, outpatient surgery center, or other outpatient setting and you can't get your medicine from a network pharmacy
- During a federally declared natural disaster or other emergency when you couldn't reasonably be expected to get medicines from a network pharmacy

In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

A9. Paying you back if you pay for a prescription

If you must use an out-of-network pharmacy, you will generally have to pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

To learn more about this, see Chapter 7.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and prescription and over-the-counter drugs covered under your Texas Medicaid benefits.

The Drug List includes both brand-name and generic drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.myamerigroup.com/TXmmp. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

B3. Drugs that are not on the Drug List

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Amerigroup STAR+PLUS MMP will not pay for the drugs listed in this section. These are called excluded drugs. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Texas Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Amerigroup STAR+PLUS MMP for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration (FDA) or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Texas Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

B4. Drug List cost sharing tiers

Every drug on the plan's Drug List is in one of four (4) cost sharing tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). In general, the higher the cost sharing tier, the higher your cost for the drug.

- Tier 1 drugs are Medicare Part D preferred generic and brand-name drugs. The copay is $0.
- Tier 2 drugs are Medicare Part D non-preferred and preferred generic and brand-name drugs. The copay is from $0-$8.50 depending on your income.
- Tier 3 drugs are Texas Medicaid/state-approved prescription drugs. The copay is $0.
- Tier 4 drugs are Medicaid-approved over-the-counter (OTC) drugs covered by Texas Medicaid with a prescription from your provider. The copay is $0.

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

Chapter 6 tells the amount you pay for drugs in each cost sharing tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, see Chapter 9.

1. **Limiting use of a brand-name drug when a generic version is available**

   Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, if there is a generic version of a brand-name drug, our network pharmacies will give you the generic version.

   - We usually will not pay for the brand-name drug when there is a generic version.
   - However, if your provider has told us the medical reason that the generic drug will not work for you ***or*** has written "No substitutions" on your prescription for a brand-name drug ***or*** has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.
   - Your copay may be greater for the brand-name drug than for the generic drug.

2. **Getting plan approval in advance**

   For some drugs, you or your doctor must get approval from Amerigroup STAR+PLUS MMP before you fill your prescription. If you don't get approval, Amerigroup STAR+PLUS MMP may not cover the drug.

   You can get a 72-hour supply of a drug covered by Texas Medicaid if it is an emergency.

3. **Trying a different drug first**

   In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

   If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at www.myamerigroup.com/TXmmp.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:
   - is no longer on the plan's Drug List, **or**
   - was never on the plan's Drug List, **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in the plan last year.
     - We will cover a temporary supply of your drug **during the first 90 days of the calendar year**.
     - This temporary supply will be for up to 31-days.
     - If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 31-days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You are new to the plan.
     - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
     - This temporary supply will be for up to 31-days.

  - If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 31-days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
  - To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- You can ask for an exception.

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your Medicare Part D drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, see Chapter 9.

If you need help asking for an exception, you can contact Member Services or your service coordinator.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but Amerigroup STAR+PLUS MMP may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval for a drug. (Prior approval is permission from Amerigroup STAR+PLUS MMP before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, see Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless**:**

- a new, cheaper drug comes along that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check Amerigroup STAR+PLUS MMP's up to date Drug List online at www.myamerigroup.com/TXmmp or
- Call Member Services to check the current Drug List at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available**. Sometimes, a new and cheaper drug comes along that works as well as a drug on the Drug List now. When that happens, we may remove the current drug, but your cost for the new drug will stay the same or will be lower.

  When we add the new generic drug, we may also decide to keep the current drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change or changes we made.

  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please see Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. Your provider will also know about this change. He or she can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.
- We add a generic drug **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will tell you at least 30 days before we make the change to the Drug List or when you ask for a refill. This will give you time to talk to your doctor or other prescriber. He or she can help you decide if there is a similar drug on the Drug List you can take instead or whether to ask for an exception. Then you can:

- Get a 31-day supply of the drug before the change to the Drug List is made, or
- Ask for an exception from these changes. To learn more about asking for exceptions, see Chapter 9.

F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

To learn more about drug coverage and what you pay, see Chapter 6.

F2. If you are in a long-term care facility

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

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Medicare Part D.

To learn more about the hospice benefit, see Chapter 4.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drugs errors or drugs that:

- May not be needed because you are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Are made of things you are allergic to

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Member Services or your service coordinator.

G3. Drug management program to help members safely use their opioid medications

Amerigroup STAR+PLUS MMP has a program that can help members safely use their prescription opioid medications or other medications that are frequently abused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from one pharmacy** and/or **from one doctor**
- **Limiting the amount** of those medications we will cover for you

If we decide that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake, you disagree that you are at risk for prescription drug abuse, or you disagree with the limitation, you and your prescriber can file an appeal. (To learn how to file an appeal, see Chapter 9.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer, **or**
- are getting hospice care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Texas Medicaid prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, **and**
- drugs and items covered under Texas Medicaid, **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Texas Medicaid, you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

> **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."

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- The plan's *List of Covered Drugs.*
  - We call this the "Drug List." It tells you:
    - Which drugs the plan pays for
    - Which of the four (4) cost sharing tiers each drug is in
    - Whether there are any limits on the drugs
  - If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at www.myamerigroup.com/TXmmp. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.
  - Chapter 5 tells how to get your outpatient prescription drugs through the plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.

- The plan's *Provider and Pharmacy Directory.*
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.

Table of Contents

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits.* We call it the EOB for short. The EOB includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.
- To find out which drugs our plan covers, see the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You can ask us to help you get paid back for our share of the cost of the drug. Contact your service coordinator for information on how to get paid back.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit

- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

To learn how to ask us to pay you back for our share of the cost of the drug, see Chapter 7.

3. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, Amerigroup STAR+PLUS MMP pays all of the costs of your Medicare Part D drugs for the rest of the year.

4. Check the reports we send you.

When you get an *Explanation of Benefits* in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under Amerigroup STAR+PLUS MMP. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, the plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through 12/31/2019. You begin this stage when you have paid a certain amount of out-of-pocket costs.

C1. The plan's cost-sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are Medicare Part D preferred generic and brand-name drugs. The copay is $0.
- Tier 2 drugs are Medicare Part D non-preferred and preferred generic and brand-name drugs. The copay is from $0-$8.50 depending on your income.
- Tier 3 drugs are Texas Medicaid/state-approved prescription drugs. The copay is $0.
- Tier 4 drugs are Medicaid-approved over-the-counter (OTC) drugs covered by Texas Medicaid with a prescription from your provider. The copay is $0.

C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. See Chapter 5 to find out when we will do that.

To learn more about these pharmacy choices, see Chapter 5 in this handbook and the plan's *Provider and Pharmacy Directory.*

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 93-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, see Chapter 5 or the *Provider and Pharmacy Directory.*

C4. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

You can contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 93-day supply	**The plan's mail-order service** A one-month or up to a 93-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 10-day supply. Coverage is limited to certain cases. See Chapter 5 for details.
Cost Sharing Tier 1 (Medicare Part D preferred generic and brand drugs)	$0	$0	$0	Please call Member Services for assistance
Cost Sharing Tier 2 (Medicare Part D preferred and non-preferred generic and brand drugs)	Generic: $0/ $1.25/$3.40 Brand: $0/ $3.80/$8.50 (depending on your level of Extra Help)	Generic: $0/ $1.25/$3.40 Brand: $0/ $3.80/$8.50 (depending on your level of Extra Help)	Generic: $0/ $1.25/$3.40 Brand: $0/ $3.80/$8.50 (depending on your level of Extra Help)	Please call Member Services for assistance
Cost Sharing Tier 3 (Texas Medicaid state-approved prescription drugs)	$0 (up to 31 days)	Mail-order is not available for drugs in Tier 3	$0 (up to 31 days)	Please call Member Services for assistance
Cost Sharing Tier 4 (Texas Medicaid (State)-approved over-the-counter (OTC) drugs; covered OTC drugs require a prescription from your provider)	$0 (up to 31 days)	Mail-order is not available for drugs in Tier 4	$0 (up to 31 days)	Please call Member Services for assistance

For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost sharing tier the drug is in and where you get it.

Cost sharing tiers are groups of drugs with the same copay. Every drug in the plan's Drug List is in one of four (4) cost sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are Medicare Part D preferred generic and brand-name drugs. The copay is $0.
- Tier 2 drugs are Medicare Part D non-preferred and preferred generic and brand-name drugs. The copay is from $0-$8.50 depending on your income.
- Tier 3 drugs are Texas Medicaid/state-approved prescription drugs. The copay is $0.
- Tier 4 drugs are Medicaid-approved over-the-counter (OTC) drugs covered by Texas Medicaid with a prescription from your provider. The copay is $0.

D1. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. See Chapter 5 to find out when we will do that.

To learn more about these pharmacy choices, see Chapter 5 in this handbook and the plan's *Provider and Pharmacy Directory.*

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 93-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, see Chapter 5 or the *Provider and Pharmacy Directory.*

D3. What you pay

During the Initial Coverage Stage, you will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

You can contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 93-day supply	**The plan's mail-order service** A one-month or up to a 93-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 10-day supply. Coverage is limited to certain cases. See Chapter 5 for details.
Cost Sharing Tier 1 (Medicare Part D preferred generic and brand drugs)	$0	$0	$0	Please call Member Services for assistance.
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Cost Sharing Tier 3 (Texas Medicaid state-approved prescription drugs)	$0 (up to 31 days)	Mail-order is not available for drugs in Tier 3	$0 (up to 31 days)	Please call Member Services for assistance.
Cost Sharing Tier 4 (Texas Medicaid (State)-approved over-the-counter (OTC) drugs; covered OTC drugs require a prescription from your provider)	$0 (up to 31 days)	Mail-order is not available for drugs in Tier 4	$0 (up to 31 days)	Please call Member Services for assistance.

For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $5,100. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year.

Your *Explanation of Benefits* reports will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the $5,100 limit. Many people do not reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $5,100 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

Typically, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, your copay will be based on the number of days of the drug that you get. We will calculate the amount you pay per day for your drug (the "daily cost sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.25. This means that the amount you pay for your drug is a little more than $0.04 per day. If you get a 7 days' supply of the drug, your payment will be a little more than $0.04 per day multiplied by 7 days, for a total payment of $0.29.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you better plan when to refill your drugs and take fewer trips to the pharmacy. The amount you pay will depend on the days' supply you get.

G. Vaccinations

Our plan covers Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

G1. What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with Amerigroup STAR+PLUS MMP to ensure that you do not have any upfront costs for a Medicare Part D vaccine.

G2. What you pay for a Medicare Part D vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
   - You will pay a copay to the doctor for the vaccine.

- Our plan will pay for the cost of giving you the shot.
- The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.

3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
   - You will pay a copay for the vaccine.
   - Our plan will pay for the cost of giving you the vaccine.

Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs

Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, see page 128.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid more than your share of the cost*;* it is your right to be paid back.
- If the services or drugs are not covered, we will tell you.

Contact Member Services or your service coordinator if you have any questions. If you do not know what you should have paid or if you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should ask the provider to bill the plan.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
    - If the provider should be paid, we will pay the provider directly.
    - If you have already paid for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill the plan. Show your Amerigroup STAR+PLUS MMP Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- Because Amerigroup STAR+PLUS MMP pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

- We may cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Please see Chapter 5 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9).
  - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it

should be covered, we will pay for our share of the cost of the service or drug. If we deny your request for payment, you can appeal our decision.

To learn how to make an appeal, see Chapter 9.

B. Sending a request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records**. You can ask your service coordinator for help.

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

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (www.myamerigroup.com/TXmmp), or you can call Member Services and ask for the form.

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

Part D:
Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington. KY 40512-4718

Part C:
Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599

You may also fax your claim form and receipts to 1-608-741-5483.

C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the service or drug, we will mail you a check for what you paid ***or*** our share of the cost. If you have not paid for the service or drug yet, we will pay the provider directly.

Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, see Chapter 9.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9.

- If you want to make an appeal about getting paid back for a health care service, go to page 159.
- If you want to make an appeal about getting paid back for a drug, go to page 168.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of the plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Your right to get information in a way that meets your needs

We must tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. You can get written materials in almost any language, including Spanish, and many more – just ask the Member Services representative.
- If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE
  (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You may also send a grievance to us in writing or by fax as noted below:

Amerigroup STAR+PLUS MMP
MMP Appeals and Grievances
Mailstop OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 1-888-458-1406

Su derecho a recibir información en una forma que satisfaga sus necesidades

Debemos informarle sobre los beneficios del plan y sus derechos de manera que pueda comprenderlos. Debemos informarle sobre sus derechos durante cada año que esté en nuestro plan.

- Llame a Servicios para miembros para obtener información de una manera que pueda comprender. Nuestro plan cuenta con personas que pueden responder preguntas en diferentes idiomas.
- Nuestro plan también puede entregarle materiales en idiomas que no sean inglés y en formatos como letra grande, Braille o audio. Puede obtener materiales escritos en casi cualquier idioma, incluido español y muchos más. Pregúntele al representante de Servicios para miembros.
- Si tiene problemas para obtener información de nuestro plan por problemas de idioma o una discapacidad y desea presentar una queja, llame a Medicare al 1-800-MEDICARE

(1-800-633-4227). Puede llamar 24 horas al día, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede presentarnos un reclamo por escrito o fax, como se indica a continuación.

Amerigroup STAR+PLUS MMP
MMP Appeals and Grievances
Mailstop OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 1-888-458-1406

B. Our responsibility to treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Age
- Appeals
- Behavior
- Claims experience
- Ethnicity
- Evidence of insurability
- Gender identity
- Genetic information
- Geographic location within the service area
- Health status
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of health care
- Religion
- Sex
- Sexual orientation
- Use of services

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.

We cannot deny services to you or punish you for exercising your rights.

- For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also visit http://www.hhs.gov/ocr for more information.

- You can also call your local Office for Civil Rights. Call 1-888-388-6332 (TTY 1-877-432-7232). Or call the Office of the Ombudsman at 1-877-787-8999 (TTY 1-800-735-2989 or 711).
- If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.
- You have the right to be treated fairly and with respect.
- Your medical records and discussions with your providers will be kept private and confidential.

C. Our responsibility ensure that you get timely access to covered services and drugs

If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

As a member of our plan:

- You have the right to a reasonable opportunity to choose a health plan and primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan.
- A PCP is the doctor or health care provider you will see most of the time and who will coordinate your care. You can find more information about choosing a PCP in Chapter 3.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    - Be told how to choose and change your health plan and your PCP.
    - Choose any health plan you want that is available in your area and choose your PCP from that plan.
    - Be told the frequency you can change plans.
    - Be told about other plans available in your area.
- You have the right to go to a women's health specialist without getting a referral. A referral is approval from your PCP to see someone that is not your PCP.

- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3.
- You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    - Work as part of a team with your provider in deciding what health care is best for you.
    - Say yes or no to the care recommended by your provider.
- You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    - Get medical care in a timely manner.
    - Get in and out of a health care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    - Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

You have rights to get information and to control how your PHI is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your PHI.

D1. How we protect your PHI

We make sure that unauthorized people do not see or change your records.

In most situations, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.

D2. You have a right to see your medical records

You have the right to look at your medical records and to get a copy of your records.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Centers for Medicare & Medicaid Services after you become eligible and sign up for our health plan. We also get it from your

doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit **www.myamerigroup.com/pages/privacy.aspx** for more information.
- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt

- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
  - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.

- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at 1-855-878-1784. If you're deaf or hard of hearing, call TTY 711.

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:

Office for Civil Rights

U.S. Department of Health and Human Services

1301 Young St., Suite 1169

Dallas, TX 75202

Phone: 1-800-368-1019

TDD: 1-800-537-7697

Fax: 214-767-0432

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at **www.myamerigroup.com/pages/privacy.aspx**.

Race, ethnicity and language

We receive race, ethnicity and language information about you from the state Medicaid agency and the Centers for Medicare & Medicaid Services. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do **not** use this information to:

- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

Your personal information

We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:

– Health

– Habits

– Hobbies

- We may get PI about you from other people or groups like:

– Doctors

– Hospitals

– Other insurance companies

- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

E. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of Amerigroup STAR+PLUS MMP, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. This is a free service. You can get written materials in almost any language, including Spanish, and many more – just ask the Member Services representative. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
    - Financial information

  - How the plan has been rated by plan members
  - The number of appeals made by members
  - How to leave the plan
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers
  - Qualifications of our network providers and pharmacies
  - How we pay providers in our network
  - For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at www.myamerigroup.com/TXmmp.
- Covered services and drugs and about rules you must follow, including:
  - Services and drugs covered by the plan
  - Limits to your coverage and drugs
  - Rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it, including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you have got

F. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7.

G. Your right to leave the plan

No one can make you stay in our plan if you do not want to. You can leave the plan at any time during the year.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.

- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- See Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- However, you must continue to receive your Medicaid services from a STAR+PLUS Medicaid managed care plan. If you would like to change plans, call the STAR+PLUS help line at 1-877-782-6440, Monday through Friday, 8 a.m. to 6 p.m. local time. TTY/TDD users can call 1-800-735-2989 or 711.

H. Your right to make decisions about your health care

H1. Your right to know your treatment options and make decisions about your health care

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

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **Say "no.**" You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask the plan for a coverage decision.

H2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

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

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Texas Medicaid like the Texas Department of Aging and Disability Services may also have advance directive forms. You can also contact Member Services to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

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

Remember, it is your choice to fill out an advance directive or not.

H3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Texas Department State Health Services Facility Licensing Group & Regulatory Licensing Unit at 1-512-458-7111.

I. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint. You also have the right to a fair hearing from the state at any time.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

You have the right to get a timely answer to a complaint.

I1. What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is **not** about discrimination for the reasons listed on page 132—you can get help in these ways by calling:

- Member Services.
- The State Health Insurance Assistance Program (SHIP). In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For details about this organization and how to contact it, see Chapter 2.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

The HHSC Office of the Ombudsman helps people enrolled in Texas Medicaid with service or billing problems. They can help you file a complaint or an appeal with our plan. The HHSC Office of the Ombudsman is an independent program and the services are free.

Call: 1-866-566-8989

TTY 1-800-735-2989. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Write: Texas Health and Human Services Commission

Office of the Ombudsman, MC H-700

P. O. Box 13247

Austin, TX 78711-3247

Online: http://www.hhsc.state.tx.us/ombudsman/

I2. How to get more information about your rights

There are several ways to get more information about your rights:

- Call Member Services.
- Call the State Health Insurance Assistance Program (SHIP). In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP).
- Contact Medicare.
  - Visit the Medicare website to read or download "Medicare Rights & Protections." (go to https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf), or
  - Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

J. Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.

- If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices. We expect you to cancel appointments in advance when you cannot keep them and to keep your scheduled appointments.

- **Pay what you owe.** As a plan member, you are responsible for these payments:

  - Medicare Part A and Medicare Part B premiums. For most Amerigroup STAR+PLUS MMP members, Medicaid pays for your Part A premium and for your Part B premium.

  - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copay (a fixed amount). Chapter 6 tells what you must pay for your drugs.

  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.**

  - If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.

  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Amerigroup STAR+PLUS MMP. Chapter 1 tells about our service area.

  - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area.

  - Also, be sure to let Medicare and Texas Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and Texas Medicaid.

  - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- Call Member Services for help if you have questions or concerns.

- You must abide by the health plan's policies and procedures. That includes the responsibility to:

  - Be sure you have approval from your primary care provider before going to a specialist.

- You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
  - Help your providers get your medical records.
  - Work as a team with your service coordinator in deciding what health care is best for you.
- If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call the HHSC Ombudsman's Office at 1-866-566-8989 for help.** This chapter explains the options you have for different problems and complaints, but you can always call the HHSC Ombudsman's Office to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, see Chapter 2 for more information on ombudsman programs.

Table of Contents

Section 1: Introduction

• Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Texas Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

• Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination," "benefit determination," "at risk-determination," or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

• Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the HHSC Ombudsman's Office

If you need help, you can always call the HHSC Ombudsman's Office. The HHSC Ombudsman's Office can answer your questions and help you understand what to do to handle your problem. See Chapter 2 for more information on ombudsman programs.

The HHSC Ombudsman's Office is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the HHSC Ombudsman's Office is 1-866-566-8989. The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). SHIP counselors can answer your questions and help you understand what to do to handle your problem. The SHIP is not connected with us or with any insurance company or health plan. The SHIP has trained counselors in every state, and services are free. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program (HICAP). The HICAP phone number is 1-800-252-3439.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website at https://www.medicare.gov.

Getting help from Texas Medicaid

You can call Texas Medicaid directly for help with problems. Here are two ways to get help from Texas Medicaid:

- Call 1-800-252-8263 or 2-1-1. TTY users should call 1-800-735-2989 or 7-1-1. The call is free.
- Visit the Texas Medicaid website (https://yourtexasbenefits.hhsc.texas.gov/).

Section 3: Problems with your benefits

• Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go to **Section 4: "Coverage decisions and appeals"** on page 154.	Skip ahead to **Section 10: "How to make a complaint"** on page 191.

Section 4: Coverage decisions and appeals

• Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Texas Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Texas Medicaid. If you or your doctor disagree with our decision, you can appeal.

• Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Member Services** at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.
- Call the **HHSC Ombudsman's Office** for free help. The HHSC Ombudsman's Office helps people enrolled in Texas Medicaid with service or billing problems. The phone number is 1-866-566-8989.
- Call the **State Health Insurance Assistance Program (SHIP)** for free help. The SHIP is an independent organization. It is not connected with this plan. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program (HICAP). The phone number is 1-800-252-3439.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form.
- You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. The form gives the person permission to act for you. You must give us a copy of the signed form.

- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
  - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section 5 on page 157** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
  - You are not getting medical care you want, and you believe our plan covers this care.
  - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with an asterisk (*) are not covered by Part D. See Section 6 on page 168 for Part D drug appeals.
  - You got medical care or services you think should be covered, but we are not paying for this care.
  - You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
  - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
    - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation

Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages 178 and 184.

- **Section 6 on page 168** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section 7 on page 178** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8 on page 184** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

If you need other help or information, please call the HHSC Ombudsman's Office at 1-866-566-8989.

Section 5: Problems about services, items, and drugs (not Part D drugs)

• Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long term care services. You can also use this section for problems with drugs that are **not** covered by Part D. Drugs in the *List of Covered Drugs* with an asterisk (*) are **not** covered by Part D. Use Section 6 for Part D drug appeals.

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

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 158 for information on asking for a coverage decision.

2. We did not approve care your doctor wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Go to Section 5.3 on page 159 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Go to Section 5.3 on page 159 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items**.**

   What you can do: You can ask us to pay you back. Go to Section 5.5 on page 166 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce or stop the service. Go to Section 5.3 on page 159 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 178 and 184 to find out more.

• Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time
- You can fax us at: 1-844-206-3448
- You can write to us at: MMP Clinical Department, 7430 Remcon Circle, Building C, Ste. 120, El Paso, TX 79912

How long does it take to get a coverage decision?

It usually takes up to 3 business days after you asked. If we don't give you our decision within 3 business days, you can appeal.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 1 business day.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time or fax us at 1-855-817-5792. For details on how to contact us, go to Chapter 2.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical care or an item you have not yet received**. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you already got.)

2. You can get a fast coverage decision **only if the standard 3 business day deadline could cause serious harm to your health or hurt your ability to function.**

   - If your doctor says that you need a fast coverage decision, we will automatically give you one.
   - If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
     - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 3 business day deadline instead.
     - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
     - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, see Section 10 on page 191.

If the coverage decision is Yes, when will I get the service or item?

You will be approved (pre-authorized) to get the service or item within 3 business days (for a standard coverage decision) or 1 business day (for a fast coverage decision) of when you asked.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

• Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal.

If you need help during the appeals process, you can call the HHSC Ombudsman's Office at 1-866-566-8989. The HHSC Ombudsman's Office is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. For additional details on how to reach us for appeals, see Chapter 2.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
    - You can submit a request to the following address:

      Grievance and Appeals Department
      Mailstop OH0205-A537
      4361 Irwin Simpson Road
      Mason, OH 45040
      Fax: 1-888-458-1406
- You may also ask for an appeal by calling us at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

The legal term for "fast appeal" is **"expedited reconsideration."**

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at www.myamerigroup.com/TXmmp.

If the appeal comes from someone besides you or your doctor or other provider, we must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Level 1 appeals” on page 163 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision. If the original decision was based on a lack of medical necessity, then the reviewer will be a physician.

If we need more information, we may ask you or your doctor for it.

When will I hear about a “standard” appeal decision?

We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 191.
- If we do not give you an answer to your appeal within 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Texas Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 163.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Texas Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 163.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 191.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Texas Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 163.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Texas Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 163.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits. You must **make the request on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice of action; or
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service while your appeal is processing.

• Section 5.4: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare and/or Texas Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Texas Medicaid** service or item, you can ask for a Level 2 Appeal (known as a Fair Hearing) with the Texas Health and Human Services Commission (HHSC) Appeals Division. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Texas Medicaid**, you will automatically get a Level 2 Appeal with the IRE. You can also ask for a Level 2 Appeal (known as a Fair Hearing) with the HHSC Appeals Division.

What is a Level 2 Appeal?

A Level 2 Appeal is an external appeal, which is done by an independent organization that is not connected to the plan. Medicare's Level 2 Appeal organization is the Independent Review Entity

(IRE). Texas Medicaid's Level 2 Appeal is known as a Fair Hearing. Requests for a Fair Hearing are filed with Amerigroup STAR+PLUS MMP, but reviewed by the HHSC Appeals Division.

My problem is about a Texas Medicaid service or item. How can I make a Level 2 Appeal?

A Level 2 Appeal for Texas Medicaid services and items is called a "Fair Hearing."

If you want to request a Fair Hearing, you must contact Amerigroup STAR+PLUS MMP in writing. We will send your Fair Hearing request to the HHSC Appeals Division. You or your representative must ask for a Fair Hearing **within 120 days** of the date on the letter tell you we were denying your Level 1 Appeal to our plan. If you have a good reason for being late, the HHSC Appeals Division may extend this deadline for you.

Mail your written request to:

Fair Hearing Coordinator
Amerigroup STAR+PLUS MMP
7430 Remcon Circle
Building C, Suite 120
El Paso, TX 79912

Or you can call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. We can help you with this request. If you need a fast decision because of your health, you should call Member Services to ask for an expedited Fair Hearing.

After your hearing request is received by the HHSC Appeals Division, you will get a packet of information letting you know the date, time, and location of the hearing. Most Fair Hearings are held by telephone. During the hearing, you or your representative can tell the hearing officer why you need the service that we denied.

The HHSC Appeals Division will give you a final decision within 90 days from the date you asked for the hearing. If you qualify for an expedited Fair Hearing, the HHSC Appeals Division must give you an answer within 72 hours. However, if the HHSC Appeals Division needs to gather more information that may help you, it can take up to 14 more calendar days.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

If you had "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

What if my service or item is covered by both Medicare and Texas Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Texas Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also ask for a Fair Hearing. Requests for a Fair Hearing are filed with Amerigroup STAR+PLUS MMP, but reviewed by the HHSC Appeals Division. Follow the instructions on page 164.

Will my benefits continue during Level 2 appeals?

If your problem is about a service covered by **Medicare or both Medicare and Texas Medicaid**, your benefits for that service will not continue during Level 2 Appeals.

If your problem is about a service covered by **Texas Medicaid only**, your benefits for that service will continue during the Level 2 Appeal if:

- Your appeal is about our decision to reduce or stop a service that was previously authorized; and
- You request a Level 2 Appeal (Fair Hearing) within 10 days of our letter telling you that we were denying your Level 1 appeal or before the intended effective date of the action, whichever is later.

How will I find out about the decision?

If your Level 2 Appeal (Fair Hearing) went to the HHSC Appeals Division, it will notify you in writing of the hearing decision.

- If the HHSC Appeals Division says **Yes** to part or all of what you asked for, we must authorize the coverage within 72 hours from the date we receive the hearing decision.
- If the HHSC Appeals Division says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I appealed to both the Independent Review Entity and the HHSC Appeals Division and they have different decisions?

If either the Independent Review Entity or the HHSC Appeals Division decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you requested in your appeal.

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

If your Level 2 Appeal (Fair Hearing) went to the HHSC Appeals Division, you may appeal again by requesting an administrative review. The letter you get from the HHSC Appeals Division will describe this next appeal option.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

See Section 9 on page 190 for more information on additional levels of appeal.

• Section 5.5: Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for certain drugs on the Amerigroup STAR+PLUS MMP Drug List.

If you get a bill that is more than your copay for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: "Asking us to pay our share of a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for your share of a service or item I paid for?

Remember, if you get a bill that is more than your copay for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of the service or item within 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 5.3 on page 159. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 on page 190 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Texas Medicaid, you can file a Level 2 Appeal yourself (see Section 5.4 on page 163).

Section 6: Part D drugs

• Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Texas Medicaid may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs* (Drug List), includes some drugs with an asterisk (*). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an asterisk (*) symbol follow the process in Section 5 on page 157.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List)
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> **The legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section 6.2** on page 169. Also see Sections 6.3 and 6.4 on pages 170 and 171.	Skip ahead to **Section 6.4** on page 171.	Skip ahead to **Section 6.4** on page 171.	Skip ahead to **Section 6.5** on page 174.

• Section 6.2: What is an exception?

An exception is permission to get coverage for a drug that is not normally on our *List of Covered Drugs* or to use the drug without certain rules and limitations. If a drug is not on our *List of Covered Drugs* or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
    - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in tier (2).

- You cannot ask for an exception to the copay or coinsurance amount we require you to pay for the drug.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5).
   - The extra rules and restrictions on coverage for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - Quantity limits. For some drugs, we limit the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

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

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 on page 174 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

• Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section 4 on page 154 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”

- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

> **The legal term** for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

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

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 191.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

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

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

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

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

• Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance*:* How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 on page 171.

> **The legal term** for "fast appeal" is **"expedited redetermination."**

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of

the appeals process. At Level 2, an Independent Review Entity will review your appeal.

- **If our answer is Yes** to part or all of what you asked for:
  - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 days if you asked us to pay you back for a drug you already bought.
  - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.

- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

> **The legal term** for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

Section 7: Asking us to cover a longer hospital stay

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

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

• Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called An Important Message from Medicare about Your Rights. If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The Important Message tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

- You can also see the notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.
- If you need help, please call Member Services or Medicare at the numbers listed above.

• Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you. In Texas, the Quality Improvement Organization is called KEPRO.

To make an appeal to change your discharge date call KEPRO at: 1-888-315-0636.

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. An Important Message from Medicare about Your Rights contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-315-0636 and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page 182.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can also call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439 or the HHSC Ombudsman's Office at 1-866-566-8989.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> **The legal** term for "fast review" is **"immediate review."**

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> **The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

• Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said No to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Texas, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-315-0636.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-315-0636 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

• Section 7.4: What happens if I miss an appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
- It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
    - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.

- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

> **The legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 191 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

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

• Section 8.1: We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage".

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying for your care.

• Section 8.2: Level 1 Appeal to continue your care

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

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 on page 191 tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. Or call your State Health Insurance Assistance Program at 1-800-252-3439.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Texas, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-315-0636. Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-888-315-0636 and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 on page 187.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

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

• Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Texas, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-315-0636. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-888-315-0636 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

• Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 191 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said No to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 9: Taking your appeal beyond Level 2

• Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the HHSC Ombudsman's Office. The phone number is 1-866-566-8989.

• Section 9.2: Next steps for Texas Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Texas Medicaid. If you have questions about your additional appeal rights, you can call the HHSC Ombudsman's Office at 1-866-566-8989.

If you do not agree with a decision given by the Fair Hearings officer, you may request an Administrative Review within 30 days of the date on the decision.

The letter you get from the HHSC Appeals Division will tell you what to do if you wish to continue the appeals process.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Amerigroup STAR+PLUS MMP staff treated you poorly.
- You think you are being pushed out of the plan.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section 10.2 on page 193.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term for a "complaint" is a **"grievance."**
The legal term for "making a complaint" is **"filing a grievance."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the HHSC Ombudsman's Office at 1-866-566-8989.

• Section 10.1: Internal complaints

To make an internal complaint, call Member Services at 1-855-878-1784 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. local time. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.

- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

• Section 10.2: External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

You can tell Texas Medicaid about your complaint

Once you have gone through the plan's complaint process, you can submit a complaint to the Texas Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services
You can also send your complaint by email to HPM_Complaints@hhsc.state.tx.us.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

U.S. Department of Health and Human Services
1301 Young St., Suite 1169
Dallas, TX 75202
Phone: 1-800-368-1019 (TDD 1-800-537-7697)
Fax: 202-619-3818

You may also have rights under the Americans with Disability Act. You can contact the HHSC Ombudsman's Office for assistance. The phone number is 1-866-566-8989.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, see Chapter 2.

In Texas, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-888-315-0636.

Chapter 10: Ending your membership in our Medicare-Medicaid Plan

Introduction

This chapter tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. If you leave our plan, you will still be in the Medicare and Texas Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

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A. When can you end your membership in our Medicare-Medicaid Plan

You can end your membership in Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month (February 1, in this example). If you leave our plan, you can get information about your:

- Medicare options in the table on page 198.
- Texas Medicaid services on page 199.

You can get more information about when you can end your membership by calling:

- STAR+PLUS MMP Help Line at 1-877-782-6440, Monday through Friday from 8 a.m. to 8 p.m. Central time. TTY users should call 1-800-735-2989.
- State Health Insurance Assistance Program (SHIP), Health Information Counseling & Advocacy Program of Texas (HICAP) at 1-800-252-3439.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

NOTE: Effective January 1, 2019, if you're in a drug management program, you may not be able to change plans. See Chapter 5 for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, tell Medicaid or Medicare that you want to leave Amerigroup STAR+PLUS MMP:

- Call STAR+PLUS MMP Help Line at 1-877-782-6440, Monday through Friday from 8 a.m. to 8 p.m. Central time. TTY/TDD users should call 1-800-735-2989; OR
- Send MAXIMUS an Enrollment Change Form. You can get the form by calling STAR+PLUS MMP Help Line at 1-877-782-6440 if you need them to mail you one; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 198.

C. How to join a different Medicare-Medicaid Plan

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call STAR+PLUS MMP Help Line at 1-877-782-6440, Monday through Friday from 8 a.m. to 8 p.m. Central time. TTY/TDD users should call 1-800-735-2989. Tell them you want to leave Amerigroup STAR+PLUS MMP and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area; OR
- Send MAXIMUS an Enrollment Change Form. You can get the form by calling the STAR+PLUS MMP Help Line at 1-877-782-6440 if you need them to mail you one.

Your coverage with Amerigroup STAR+PLUS MMP will end on the last day of the month that we get your request.

D. How to get Medicare and Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave Amerigroup STAR+PLUS MMP, you will go back to getting your Medicare and Medicaid services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE)**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). You will automatically be disenrolled from Amerigroup STAR+PLUS MMP when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). You will automatically be disenrolled from Amerigroup STAR+PLUS MMP when your Original Medicare coverage begins.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call your Health Information Counseling & Advocacy Program (HICAP) at 1-800-252-3439.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). You will automatically be disenrolled from Amerigroup STAR+PLUS MMP when your Original Medicare coverage begins.

D2. How to get your Medicaid services

Your Texas Medicaid services include most long-term services and supports and behavioral health care.

If you leave the Medicare-Medicaid plan, you will remain in our plan to get your Medicaid services.

- You can choose to switch to another Medicaid-only health plan by contacting MAXIMUS at 1-877-782-6440 or the STAR+PLUS Help Line at 1-877-782-6440, Monday through Friday from 8 a.m. to 8 p.m. Central time. TTY users should call 1-800-735-2989.
- You will get a new Member ID Card, a new *Member Handbook*, and a new *Provider and Pharmacy Directory*.

E. Keep getting your medical services and drugs through our plan until your membership ends

If you leave Amerigroup STAR+PLUS MMP, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. See page 196 for more information. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

These are the cases when Amerigroup STAR+PLUS MMP must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Texas Medicaid. Our plan is for people who qualify for both Medicare and Texas Medicaid.
- If you do not pay the amount needed for you to qualify for benefits (medical spend down).
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.

You must be a United States citizen or lawfully present in the United States to be a member of our plan. The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis. We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Texas Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week. You should also call Texas Medicaid. Please call 1-800-252-8263. If you are deaf or hard of hearing, please call 1-800-735-2989.

H. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also see Chapter 9 for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at 1-855-878-1784 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m. local time.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in 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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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Texas Medicaid must obey the law. You cannot be treated differently because of your age, claims experience, color, creed, ethnicity, evidence of insurability, gender, genetic information, geographic location, health status, medical history, mental or physical disability, national origin, race, religion, or sex.

If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information. You may also call the Texas Health and Human Services Civil Rights Office at 1-888-388-6332.

C. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services. As a member of Amerigroup STAR+PLUS MMP, you only have to pay the plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $5,100 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 [plans may insert reference, as applicable] explains how to contact CMS.

Clinical Practice Guidelines (CPG): A written or spoken statement that includes suggestions to make your care better.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive Health Risk Assessment: An assessment used to confirm your appropriate risk level and to develop your Plan of Care. Comprehensive Health Risk Assessments will include, but not be limited to, physical and behavioral health, social needs, functional status, wellness and prevention domains, caregiver status and capabilities, as well as your preferences, strengths, and goals.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get a service or supply. For example, you might pay $2 or $5 for a service or a prescription drug.

Cost sharing: Amounts you have to pay when you get services or drugs. Cost sharing includes copays and coinsurance.

Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of four (4) cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Cultural Competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Daily cost sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.25. This means that the amount you pay for your drug is a little more than $0.04 per day. If you get a 7 days' supply of the drug, your payment will be a little more than $0.04 per day multiplied by 7 days, for a total payment of $0.29.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *List of Covered Drugs* is in one of four (4) tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home.

Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: 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."

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, 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.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- Amerigroup STAR+PLUS MMP must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Amerigroup STAR+PLUS MMP Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

Because Amerigroup STAR+PLUS MMP pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Initial coverage stage: The stage before your total Part D drug expenses reach $5,100. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

***List of Covered Drugs* (Drug List):** A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): See "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- See Chapter 2 for information about how to contact Medicaid in your state.

Medically necessary: Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart. When we give our decision, we base it on two things. First there are Medicare's rules. Second there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for Urgent care, Emergency care or Renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Member Services. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed Plan of Care (see "Health plan").

Medicare Advantage Plan: A Medicare program, also known as "Medicare Part C" or "MA Plans," that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare-Medicaid Plan (MMP): 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.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Amerigroup STAR+PLUS MMP includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 [plans may insert reference, as applicable] for information about how to contact Member Services.

Model of care: This is the way we deliver health care through our plan. With Amerigroup STAR+PLUS MMP, you have a main doctor, primary care provider, and a care manager who helps you keep track of your services and make your care plan.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers, amounts that are set by Congress.

- You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. See the definition for "cost sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. See Amerigroup STAR+PLUS MMP's Notice of Privacy Practices for more information about how Amerigroup STAR+PLUS MMP protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Plan of Care: A person-centered Plan of Care that addresses health care services you will get and how you will get them. The plan is developed by the Service Coordinator with you, your family, as appropriate, and your providers. The Plan of Care will contain your health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who will provide such services.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems.

- He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must see your primary care provider before you see any other health care provider.
- See Chapter 3 for information about getting care from primary care providers.

Prior authorization: An approval from Amerigroup STAR+PLUS MMP you must get before you can get a specific service or drug or see an out-of-network provider. Amerigroup STAR+PLUS MMP may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

- Covered services that need our plan's prior authorization are marked in the Benefits Chart in Chapter 4.

Some drugs are covered only if you get prior authorization from us.

- Covered drugs that need our plan's prior authorization are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can see someone that is not your PCP. If you don't get approval, Amerigroup STAR+PLUS MMP may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4 to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get Amerigroup STAR+PLUS MMP.

Service coordination team: A service coordination team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your service coordination team will also help you make a Plan of Care.

Service Coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The Texas Health and Human Services Commission (HHSC) is the single state agency responsible for operating, and in some cases, supervising, the state's Medicaid program.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

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 non-English speakers.
TTY	711 Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m. local time.
WRITE	Amerigroup STAR+PLUS MMP MMP Member Services 7430 Remcon Circle Building C, Suite 120 El Paso, TX 79912
WEB SITE	www.myamerigoup.com/TXmmp

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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