# Vantage
## Medicare Advantage

AFFINITY HEALTH NETWORK

# 2023

## EVIDENCE OF COVERAGE

Your Medicare Health Benefits and Service and Prescription Drug Coverage as a Member of Vantage Health Plan.

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**711**

# Vantage STANDARD (HMO-POS)

## Medicare Advantage HMO

January 1, 2023 - December 31, 2023

This booklet gives the details about your Medicare healthcare and prescription drug coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place. For more information, visit ***www.VantageMedicare.com***. Other providers or physicians are available in Vantage's network.

Call seven days a week
October 1, 2022 - March 31, 2023
8:00 A.M. - 8:00 P.M. CST

After March 31, 2023,
Monday - Friday
8:00 A.M. - 8:00 P.M. CST
An answering service will operate on weekends and holidays.

VANTAGE HEALTH PLAN

MedicareRx Prescription Drug Coverage

**January 1 – December 31, 2023**

# Evidence of Coverage:

## Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Vantage STANDARD (HMO-POS)

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

**For questions about this document, please contact Member Services at 1-866-704-0109 for additional information. (TTY users should call 711.) Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST.**

This plan, Vantage STANDARD (HMO-POS), is offered by Vantage Health Plan, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Vantage Health Plan, Inc. When it says "plan" or "our plan," it means Vantage STANDARD (HMO-POS).)

Member Services has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

You may access your Vantage plan documents, including this 2023 *Evidence of Coverage*, via the Vantage website instead of traditional paper booklets. You can view Vantage plan documents at www.VantageMedicare.com, or download them from the website. You may also request copies of your documents by contacting Member Services at the phone number on the back cover of this booklet.

In addition to digital format, we can also give you this information in large print, languages other than English, and other accessible formats.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;



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

- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

## 2023 Evidence of Coverage

## Table of Contents

**CHAPTER 1** ***Getting started as a member*** ..... **8**

SECTION 1 Introduction ..... 8

SECTION 2 What makes you eligible to be a plan member? ..... 9

SECTION 3 Important membership materials you will receive ..... 10

SECTION 4 Your monthly costs for Vantage STANDARD (HMO-POS) ..... 11

SECTION 5 More information about your monthly premium ..... 14

SECTION 6 Keeping your plan membership record up to date ..... 16

SECTION 7 How other insurance works with our plan ..... 17

**CHAPTER 2** ***Important phone numbers and resources*** ..... **20**

SECTION 1 Vantage STANDARD (HMO-POS) contacts (how to contact us, including how to reach Member Services) ..... 20

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program) ..... 23

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare) ..... 25

SECTION 4 Quality Improvement Organization ..... 26

SECTION 5 Social Security ..... 26

SECTION 6 Medicaid ..... 27

SECTION 7 Information about programs to help people pay for their prescription drugs ..... 28

SECTION 8 How to contact the Railroad Retirement Board ..... 31

SECTION 9 Do you have "group insurance" or other health insurance from an employer? ..... 31

**CHAPTER 3** ***Using the plan for your medical services*** ..... **34**

SECTION 1 Things to know about getting your medical care as a member of our plan ..... 34

SECTION 2 Use providers in the plan's network to get your medical care ..... 35

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster ..... 39

SECTION 4 What if you are billed directly for the full cost of your services? ..... 41

SECTION 5 How are your medical services covered when you are in a "clinical research study"? ..... 41

SECTION 6 Rules for getting care in a "religious non-medical health care institution" ..... 43
SECTION 7 Rules for ownership of durable medical equipment..... 44

**CHAPTER 4 *Medical Benefits Chart (what is covered and what you pay)* ..... 47**
SECTION 1 Understanding your out-of-pocket costs for covered services ..... 47
SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay ..... 49
SECTION 3 What services are not covered by the plan? ..... 112

**CHAPTER 5 *Using the plan's coverage for Part D prescription drugs*..... 123**
SECTION 1 Introduction ..... 123
SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service..... 123
SECTION 3 Your drugs need to be on the plan's "Drug List"..... 126
SECTION 4 There are restrictions on coverage for some drugs ..... 128
SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered? .. 129
SECTION 6 What if your coverage changes for one of your drugs? ..... 132
SECTION 7 What types of drugs are *not* covered by the plan? ..... 134
SECTION 8 Filling a prescription ..... 134
SECTION 9 Part D drug coverage in special situations ..... 135
SECTION 10 Programs on drug safety and managing medications..... 136

**CHAPTER 6 *What you pay for your Part D prescription drugs* ..... 140**
SECTION 1 Introduction ..... 140
SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug..... 142
SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in..... 143
SECTION 4 During the Deductible Stage, you pay the full cost of your Tier 4 and Tier 5 drugs 144
SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share ..... 144
SECTION 6 Costs in the Coverage Gap Stage ..... 149
SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs ..... 149
SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them ..... 150

**CHAPTER 7** ***Asking us to pay our share of a bill you have received for covered medical services or drugs*** ..... **153**

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs ..... 153

SECTION 2 How to ask us to pay you back or to pay a bill you have received ..... 155

SECTION 3 We will consider your request for payment and say yes or no ..... 156

**CHAPTER 8** ***Your rights and responsibilities*** ..... **158**

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan 158

SECTION 2 You have some responsibilities as a member of the plan ..... 169

**CHAPTER 9** ***What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*** ..... **172**

SECTION 1 Introduction ..... 172

SECTION 2 Where to get more information and personalized assistance ..... 172

SECTION 3 To deal with your problem, which process should you use? ..... 173

SECTION 4 A guide to the basics of coverage decisions and appeals ..... 173

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision ..... 176

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal ..... 183

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon ..... 192

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon ..... 198

SECTION 9 Taking your appeal to Level 3 and beyond ..... 204

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns ..... 206

**CHAPTER 10** ***Ending your membership in the plan*** ..... **211**

SECTION 1 Introduction to ending your membership in our plan ..... 211

SECTION 2 When can you end your membership in our plan? ..... 211

SECTION 3 How do you end your membership in our plan? ..... 213

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan ..... 214

SECTION 5 Vantage STANDARD (HMO-POS) must end your membership in the plan in certain situations ..... 214

**CHAPTER 11 *Legal notices*..... 218**

SECTION 1 Notice about governing law ..... 218
SECTION 2 Notice about nondiscrimination ..... 218
SECTION 3 Notice about Medicare Secondary Payer subrogation rights ..... 218
SECTION 4 Notice about communications ..... 218
SECTION 5 Notice about affirmative statement ..... 219
SECTION 6 Third party liability and subrogation ..... 219
SECTION 7 Member liability ..... 220
SECTION 8 Medicare-covered services must meet requirement of reasonable and necessary ... 220
SECTION 9 Non duplication of benefits with automobile, accident or liability coverage ..... 220
SECTION 10 Acts beyond our control ..... 221
SECTION 11 Contracting medical providers and network hospitals are independent contractors 221
SECTION 12 Technology assessment ..... 221
SECTION 13 Information upon request ..... 222
SECTION 14 Enrollee Fraud & Abuse Communication ..... 222

**CHAPTER 12 *Definitions of important words* ..... 224**

# CHAPTER 1:

*Getting started as a member*

# SECTION 1 Introduction

## Section 1.1 You are enrolled in Vantage STANDARD (HMO-POS), which is a Medicare HMO Point-of-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Vantage STANDARD (HMO-POS). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Vantage STANDARD (HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.) A network consists of facilities, physicians, other healthcare professionals, pharmacies, and suppliers our plan has contracted with to provide health care services.

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

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

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of Vantage STANDARD (HMO-POS).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Member Services.

## Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Vantage STANDARD (HMO-POS) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Vantage STANDARD (HMO-POS) between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can

change the costs and benefits of Vantage STANDARD (HMO-POS) after December 31, 2023. We can also choose to stop offering the plan in your service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve Vantage STANDARD (HMO-POS) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

### Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States

### Section 2.2 Here is the plan service area for Vantage STANDARD (HMO-POS)

Vantage STANDARD (HMO-POS) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these parishes in Louisiana: Allen, Avoyelles, Bossier, Caddo, Calcasieu, Catahoula, De Soto, East Baton Rouge, East Carroll, Evangeline, Franklin, Jefferson, LaSalle, Lincoln, Morehouse, Ouachita, Rapides, Richland, Sabine, St. Helena, St. Landry, Tangipahoa, Tensas, Terrebonne, Vernon, Webster, West Carroll, and Winn.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

### Section 2.3 U.S. Citizen or Lawful Presence

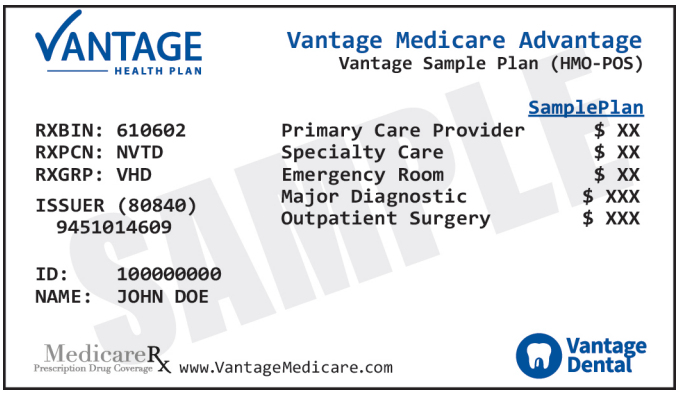
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Vantage STANDARD (HMO-POS) if you are not eligible to remain a member on this basis. Vantage STANDARD (HMO-POS) must disenroll

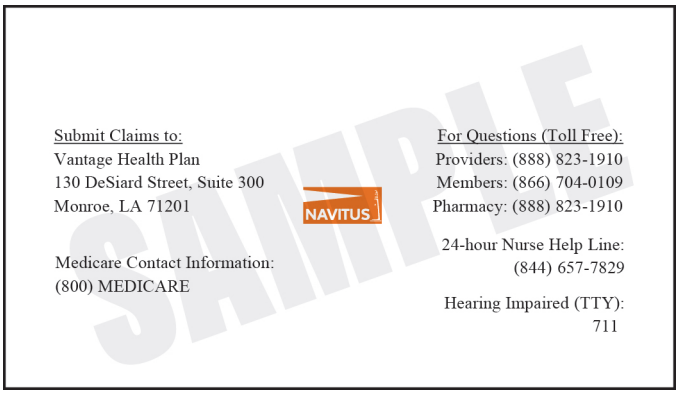
you if you do not meet this requirement.

## SECTION 3 Important membership materials you will receive

### Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:




Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Vantage STANDARD (HMO-POS) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

### Section 3.2 Provider Directory

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

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Vantage STANDARD (HMO-POS) authorizes use of out-of-network providers.

Our plan does offer a Point of Service (POS) option for certain services. POS is an HMO option that lets a member use out-of-network providers for an additional cost. All services obtained from out-of-network

providers require prior authorization (except emergency services, supplemental dental services, supplemental vision services, supplemental hearing services, urgently needed care when the network is not available and dialysis outside the plan's service area) and are subject to a $500 deductible and fifty percent (50%) coinsurance. **The maximum plan benefit for out-of-network covered services is $5,000. Once the plan has paid $5,000 for benefits, you will pay 100% of all out-of-network services for the rest of the calendar year.**

The most recent list of providers and suppliers is available on our website at www.VantageMedicare.com.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services.

## Section 3.3 Pharmacy Directory

The *Pharmacy Directory* lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services. You can also find this information on our website at www.VantageMedicare.com.

## Section 3.4 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Vantage STANDARD (HMO-POS). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Vantage STANDARD (HMO-POS) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.VantageMedicare.com) or call Member Services.

# SECTION 4 Your monthly costs for Vantage STANDARD (HMO-POS)

Your costs may include the following:
- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)

- Income Related Monthly Adjusted Amount (Section 4.4)

### In some situations, your plan premium could be less

The "Extra Help" program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage*** may **not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services, and ask for the "LIS Rider."

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

## Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2023, the monthly premium for Vantage STANDARD (HMO-POS) is $38.40.

## Section 4.2 Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to remain a member of the plan**. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

## Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly or quarterly premium. When you first enroll in

Vantage STANDARD (HMO-POS), we let you know the amount of the penalty.
If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note**: Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note**: The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

**Medicare determines the amount of the penalty**. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is $34.71.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $34.71, which equals $4.86. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

**If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review**. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

**Important:** Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

## Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

# SECTION 5 More information about your monthly premium

## Section 5.1 There are several ways you can pay your plan premium

There are five ways you can pay your plan premium.

### Option 1: Paying by cash, money order or check

You may decide to pay your plan premium directly to our plan monthly, quarterly (pre-pay only), or annually (pre-pay only). Premium payments are due on the first day of the calendar month and must be received by the fifth of each calendar month if the premium is paid on a monthly basis. Checks or money orders should be made payable to **Vantage Health Plan** and should be mailed to 130 DeSiard Street, Suite 300, Monroe, LA 71201 or delivered in person to the same address. We will charge $35 for all returned checks.

### Option 2: You can have your monthly premium automatically drafted

Instead of paying by cash, money order or check, you can have your monthly plan premium automatically withdrawn from your checking or savings account, charged directly to most credit cards, or charged directly to your debit card. These transactions are completed on the fifth of each calendar month. When choosing one of these options, the "ACH/Credit Card" form must be completed and returned to the address listed above in Option 1. You can request this form by calling Member Services at the number on the back cover of this book or by visiting our website (www.vantagemedicare.com). Automatic withdrawals from your bank account also require a voided check to be attached to the completed form.

### Option 3: Having your plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

### Option 4: You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) check

You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) check. Contact Member Services for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.) It can take up to 90 days to receive withhold acceptance. RRB will begin deducting on the date of acceptance. You will receive an invoice for any months prior to the withhold acceptance date by RRB, which will be your responsibility to pay. In limited circumstances, Medicare may not allow for the RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing.

### Option 5: Pay online by credit card or debit card

Log in to your secure account at members.vantagehealthplan.com (or create an account). You only need your credit/debit card information to process a payment. You will get a confirmation email when you make your payment. Your credit/debit card statement will show a payment made to "Vantage Health Plan".

**Changing the way you pay your premium.** If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, a request must be submitted in writing to change your payment option to Social Security deduction or monthly direct bill. An "ACH/Credit Card" form must be completed to change your payment option to automatic withdrawal from your bank account, credit card or debit card.

### What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the calendar month. If we have not received your payment by the first day of the calendar month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 60 days. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at 1-866-704-0109. Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

### Section 5.2 Can we change your monthly plan premium during the year?

**No.** We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

## SECTION 6 Keeping your plan membership record up to date

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

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

### Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Louisiana Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note**: You are not required to tell your plan about the clinical research studies, you intend to participate in, but we encourage you to do so)

If any of this information changes, please let us know by calling Member Services.

Members may request to update choice of Primary Care Provider via the Vantage member portal at members.vantagehealthplan.com. Contact Member Services for more information about using the portal.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

## SECTION 7 How other insurance works with our plan

### Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

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

# CHAPTER 2:

## *Important phone numbers and resources*

## SECTION 1 Vantage STANDARD (HMO-POS) contacts (how to contact us, including how to reach Member Services)

### How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Vantage STANDARD (HMO-POS) Member Services. We will be happy to help you.

| Method | Member Services – Contact Information |
|---|---|
| **CALL** | 1-866-704-0109<br>Calls to this number are free.<br>1-318-361-0900<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST.<br><br>An answering service will operate on weekends and holidays. When leaving a message, please leave your name, number and the time you called, and a representative will return your call.<br><br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. |
| **FAX** | 1-318-361-2181 |
| **WRITE** | Vantage Health Plan, Inc.<br>130 DeSiard Street, Suite 300<br>Monroe, LA 71201 |
| **WEBSITE** | www.VantageMedicare.com |

## How to contact us when you are asking for a coverage decision or appeal about your medical care or your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

| Method | Coverage Decisions and Appeals For Medical Care or your Part D prescription drugs – Contact Information |
|---|---|
| **CALL** | 1-866-704-0109<br>Calls to this number are free.<br>1-318-361-0900<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. An answering service will operate on weekends and holidays. When leaving a message, please leave your name, number and the time you called, and a representative will return your call. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. |
| **FAX** | 1-318-361-2181<br>1-318-361-2170 (Expedited requests) |
| **WRITE** | Vantage Health Plan, Inc.<br>130 DeSiard Street, Suite 300<br>Monroe, LA 71201 |

## How to contact us when you are making a complaint about your medical care or your Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For

more information on making a complaint about your medical care or your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

| Method | Complaints About Medical Care or your Part D prescription drugs – Contact Information |
|---|---|
| **CALL** | 1-866-704-0109<br>Calls to this number are free.<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. – 8:00 p.m. CST. An answering service will operate on weekends and holidays. When leaving a message, please leave your name, number and the time you called, and a representative will return your call. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. |
| **FAX** | 1-318-361-2181<br>1-318-361-2170 (expedited complaints) |
| **WRITE** | Vantage Health Plan, Inc.<br>130 DeSiard Street, Suite 300<br>Monroe, LA 71201 |
| **MEDICARE WEBSITE** | You can submit a complaint about Vantage STANDARD (HMO-POS) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. |

## Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)*.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals,*

*complaints))* for more information.

| Method | Payment Requests – Contact Information |
|---|---|
| **CALL** | 1-866-704-0109<br>Calls to this number are free.<br>1-318-361-0900<br><br>Member Services will operate seven (7) days a week from 8:00 a.m.- 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. An answering service will operate on weekends and holidays. When leaving a message, please leave your name, number and the time you called, and a representative will return your call. |
| **TTY** | 711<br><br>Calls to this number are free.<br><br>Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. |
| **FAX** | 1-318-361-2181 |
| **WRITE** | Vantage Health Plan, Inc.<br>130 DeSiard Street, Suite 300<br>Monroe, LA 71201 |
| **WEBSITE** | www.VantageMedicare.com |

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

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

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

| Method | Medicare – Contact Information |
|---|---|
| **CALL** | 1-800-MEDICARE, or 1-800-633-4227<br>Calls to this number are free.<br>24 hours a day, 7 days a week. |
| **TTY** | 1-877-486-2048<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. |
| **WEBSITE** | www.medicare.gov<br>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.<br>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:<br>• **Medicare Eligibility Tool:** Provides Medicare eligibility status information.<br>• **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.<br>You can also use the website to tell Medicare about any complaints you have about Vantage STANDARD (HMO-POS):<br>• **Tell Medicare about your complaint:** You can submit a complaint about Vantage STANDARD (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) |

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Louisiana, the SHIP is called Senior Health Insurance Information Program (SHIIP).

Senior Health Insurance Information Program (SHIIP) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Senior Health Insurance Information Program (SHIIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior Health Insurance Information Program (SHIIP) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on "**Talk to Someone**" in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

| Method | Senior Health Insurance Information Program (SHIIP) – Contact Information |
|---|---|
| **CALL** | 1-800-259-5300<br>1-225-342-5301<br>8 a.m. - 4:30 p.m. local time, Monday - Friday |
| **TTY** | 711 |
| **WRITE** | Louisiana Department of Insurance<br>PO Box 94214<br>Baton Rouge, LA 70802 |

| Method | Senior Health Insurance Information Program (SHIIP) – Contact Information |
|---|---|
| **WEBSITE** | http://www.ldi.la.gov/consumers/senior-health-shiip |

## SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Louisiana, the Quality Improvement Organization is called KEPRO - Louisiana's Quality Improvement Organization.

KEPRO - Louisiana's Quality Improvement Organization has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO - Louisiana's Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact KEPRO - Louisiana's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

| Method | KEPRO - Louisiana's Quality Improvement Organization – Contact Information |
|---|---|
| **CALL** | 1-888-315-0636<br>9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays |
| **TTY** | 711 |
| **WRITE** | KEPRO<br>5201 W. Kennedy Blvd., Suite 900<br>Tampa, FL 33609 |
| **WEBSITE** | https://www.keproqio.com/ |

## SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal

Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

| Method | Social Security– Contact Information |
|---|---|
| **CALL** | 1-800-772-1213<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day. |
| **TTY** | 1-800-325-0778<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday. |
| **WEBSITE** | www.ssa.gov |

## SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Healthy Louisiana (Medicaid).

| Method | Healthy Louisiana (Medicaid) – Contact Information |
|---|---|
| **CALL** | 1-855-229-6848<br>8 a.m. - 5 p.m. CT, Monday - Friday |
| **TTY** | 1-855-526-3346<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WRITE** | Healthy Louisiana<br>P.O. Box 1097<br>Atlanta, GA 30301-9913 |
| **WEBSITE** | https://www.myplan.healthy.la.gov/learn |

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

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

### Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or

- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Any of the following forms of evidence is accepted to establish the subsidy status of a full benefit dual eligible or MSP-eligible beneficiary when provided by the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary:
  1. A copy of the beneficiary's Louisiana Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year;
  2. A copy of a state document that confirms active Louisiana Medicaid status during a month after June of the previous calendar year;
  3. A printout from the State electronic enrollment file showing Louisiana Medicaid status during a month after June of the previous calendar year;
  4. A screen print from the State's Louisiana Medicaid systems showing Louisiana Medicaid status during a month after June of the previous calendar year;
  5. Other documentation provided by the State showing Louisiana Medicaid status during a month after June of the previous calendar year;
  6. A letter from SSA showing that the individual receives SSI; or,
  7. An application filed by a Deemed Eligible Individual confirming that the beneficiary is automatically eligible for extra help.
- Any one of the following forms of evidence is accepted from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized or, beginning on a date specified by the Secretary, but no earlier than January 1, 2012, is an individual receiving home and community based services (HCBS) and qualifies for zero cost-sharing:
  1. A remittance from the facility showing Louisiana Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
  2. A copy of a state document that confirms Louisiana Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
  3. A screen print from the State's Louisiana Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Louisiana Medicaid payment purposes during a month after June of the previous calendar year.
  4. Effective as of a date specified by the Secretary, but no earlier than January 1, 2017, a copy of:
     a. A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
     b. A State-approved HCBS Service Plan that includes the beneficiary's name and effective date

beginning during a month after June of the previous calendar year;

c. A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,

e. A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

If you would like assistance with obtaining best available evidence or need information on providing this evidence to Vantage STANDARD (HMO-POS), please call Member Services. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Member Services if you have questions.

**What if you have coverage from an AIDS Drug Assistance Program (ADAP)?**
**What is the AIDS Drug Assistance Program (ADAP)?**

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through The Louisiana Health Access Program (ADAP).

**Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call The Louisiana Health Access Program (ADAP).

The AIDS Drug Assistance Program in your state is listed below.

| Method | The Louisiana Health Access Program (ADAP) |
|---|---|
| **CALL** | 1-504-568-7474<br>8 a.m. - 5 p.m. local time, Monday - Friday |
| **TTY** | 711 |
| **WRITE** | Attn: LA HAP<br>1450 Poydras St, Suite 2136<br>New Orleans, LA 70112 |

| Method | The Louisiana Health Access Program (ADAP) |
|---|---|
| **WEBSITE** | http://new.dhh.louisiana.gov/index.cfm/page/1118 |

Vantage STANDARD (HMO-POS) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35. Please go to Chapter 6, Section 2 for more information about your coverage during the Coverage Gap stage. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by "SI" listed in the Drug List. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).

## SECTION 8 How to contact the Railroad Retirement Board

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

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

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

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

enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

# CHAPTER 3:

## *Using the plan for your medical services*

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

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

### Section 1.1 What are "network providers" and "covered services"?

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies equipment and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

### Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Vantage STANDARD (HMO-POS) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Vantage STANDARD (HMO-POS) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - Your network PCP will coordinate the care you receive from other providers. In most situations, our plan must give you approval in advance before you can use other providers in the plan's network,

such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "prior authorization." For more information about this, see Section 2.3 of this chapter.

- Prior authorizations from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- **You should receive your care from a network provider** (for more information about this, see Section 2 in this chapter). Our plan does offer a Point of Service (POS) option for certain services. Most services obtained from out-of-network providers require prior authorization and are subject to a $500 deductible and fifty percent (50%) coinsurance. **The maximum plan benefit for out-of-network covered services is $5,000. Once the plan has paid $5,000 for benefits, you will pay 100% of all out-of-network services for the rest of the calendar year.** See the Medical Benefits Chart in Chapter 4, Section 2.1 for detailed benefits which are covered under the POS option.

  If you receive care from an out-of-network provider (a provider who is not part of our plan's network), such services will not be covered unless you obtain a prior authorization. *Here are two exceptions:*

  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible.

## SECTION 2 Use providers in the plan's network to get your medical care

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

#### What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, you must choose a plan provider to be your Primary Care Provider (PCP). Your PCP is a healthcare professional who specializes in Family or General Practice, Internal Medicine, or Pediatrics and who meets state requirements and is trained to give you routine or basic medical care as well as arrange or coordinate the rest of the covered services you get as a member of our plan. This includes:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Home health, and

- Follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

### How do you choose your PCP?

You can choose the PCP you want from the plan's panel of providers. This plan includes PCPs in the Affinity Health Network (AHN) in addition to PCPs in the standard Vantage network. Cost share for PCP office visits, Specialist office visits, hospital outpatient surgery, and other hospital outpatient services will be lower if the provider delivering the covered services is in AHN. Providers in AHN will be listed on the website, www.VantageMedicare.com, and in the *Provider Directory*.

Each member can select his/her own personal PCP from the AHN or the standard network PCPs who specialize in Family or General Practice, Pediatrics, or Internal Medicine. Your selection can be made from the *Provider Directory*, by contacting Member Services, or by visiting our website for a complete listing at www.VantageMedicare.com. Once your choice is made, you can call Member Services or fill out a member change form which is located on our website. Once we receive this information, the provider you selected will immediately be added to your membership record.

PCP selection is a very personal and private decision and Vantage would like you to be comfortable with your choice. You have the option of changing your selection at any time and you may change as often as you like.

### Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. If this happens, you will have to switch to another provider who is part of our plan. Your selection of PCP could result in being limited to specific specialists or hospitals to which that PCP refers.

Member Services can assist you in finding and selecting another provider. Phone numbers for Member Services are on the back cover of this booklet. They will check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. Members may also change their choice of PCP in the Vantage Member Portal at members.vantagehealthplan.com.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)
- Other services as listed in Chapter 4, Section 2.1 of the Medical Benefits Chart, as long as they are not marked for approval in advance and you get them from a network provider.

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

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

When your PCP thinks that you need specialized treatment, he/she will be responsible for arranging appropriate care with other qualified health care professionals, specialists or facilities, such as radiologists, laboratories, surgeons, and hospitals. If the specialist wants you to come back for more visits, your specialist can contact our plan for approval of additional visits.

For some types of services, you may need to get approval in advance from our plan (this is called getting "*prior authorization*"). Network providers whose services require an authorization are required to assist in obtaining the prior authorization, but the member remains ultimately responsible. Refer to Chapter 4, Section 2.1 for information about which services require prior authorization. For example:

- Durable medical equipment
- Inpatient treatment
- Major diagnostic testing
- Outpatient therapy
- Surgery

It is very important to get a prior authorization from us before you obtain such services. **If you do not have a prior authorization (approval in advance) before you get such services, you may have to pay for these services yourself.**

Your selection of a PCP could result in being limited to specific specialists or hospitals to which that PCP refers.

### What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization may be required.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

Our plan does offer a Point of Service (POS) option for certain services. All services obtained from out-of-network providers require prior authorization (except emergency services, supplemental dental services, supplemental vision services, supplemental hearing services, urgently needed care when the network is not available and dialysis outside the plan's service area) and are subject to a $500 deductible and fifty percent (50%) coinsurance. **The maximum plan benefit for out-of-network covered services is $5,000. Once the plan has paid $5,000 for benefits, you will pay 100% of all out-of-network services for the rest of the calendar year. The member is ultimately responsible for obtaining prior authorization for all services performed by out-of-network providers.**

See the Medical Benefits Chart in Chapter 4, Section 2.1 for detailed benefits which are covered under the POS option.

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

### Section 3.1 Getting care if you have a medical emergency

#### What is a "medical emergency" and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the world, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. If you need assistance, call Vantage Health Plan, Inc. at 1-318-361-0900 or toll-free 1-866-704-0109 (TTY users should call 711). Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2022 - March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST. Our Member Services number is also on the back of your membership ID card.

#### What is covered if you have a medical emergency?

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

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

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

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

#### What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a

medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- *– or –* The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

## Section 3.2 Getting care when you have an urgent need for services

### What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

The *Provider Directory* includes a list of network Urgent Care Centers in your area. Many urgent care walk-in clinics are open after hours, on weekends, and holidays, but may not be open 24 hours. Carry your Vantage insurance card with you. Contact your PCP as soon as possible so he or she can coordinate your follow-up care when you return home.

Our plan covers worldwide emergency services outside the United States under the following circumstances: You have a medical emergency which requires emergency care. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Emergency Care is covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition. Our plan does not cover urgently needed services or any other non-emergent services if you receive the care outside of the United States.

## Section 3.3 Getting care during a disaster

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

Please visit the following website: www.VantageMedicare.com for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

### Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

### Section 4.2 If services are not covered by our plan, you must pay the full cost

Vantage STANDARD (HMO-POS) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, if you receive your annual wellness exam but choose to have a second one within the same plan year, you will have to pay the full cost of the second annual wellness exam. Paying for costs once a benefit limit has been reached will not count toward your out-of-pocket maximum.

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

### Section 5.1 What is a "clinical research study"?

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

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study, and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

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

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

### Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions

apply:

- You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
- – *and* – you must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.

Our plan's Inpatient Hospital coverage limits apply to this benefit (see Chapter 4, Section 2.1 of this *Evidence of Coverage* for limitations).

## SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Vantage STANDARD (HMO-POS), however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services for more information.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

## Section 7.2 Rules for oxygen equipment, supplies, and maintenance

### What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Vantage STANDARD (HMO-POS) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Vantage STANDARD (HMO-POS) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

# CHAPTER 4:

*Medical Benefits Chart (what is covered and what you pay)*

# SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Vantage STANDARD (HMO-POS). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

## Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

## Section 1.2 What is your plan deductible?

There is no deductible for services provided by in-network providers.

Your yearly deductible for Point of Service (POS) benefits is $500. Until you have paid the deductible amount, you must pay the full cost of your out-of-network covered services. Once you have paid your deductible, we will begin to pay our share of the costs for out-of-network covered medical services and you will pay your share (your coinsurance amount). **The maximum plan benefit for out-of-network covered services is $5,000. Once the plan has paid $5,000 for benefits, you will pay 100% of all out-of-network services for the rest of the calendar year.**

The POS deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you have not paid your POS deductible yet. The POS deductible does not apply to the following services:

- *Emergency care*
- *Urgently needed services when network providers are temporarily unavailable or inaccessible.*
- *Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area*
- *Non-Medicare-covered services:*
  - *Preventive dental*
  - *Comprehensive dental*
  - *Routine eye exam*
  - *Eyewear*
  - *Routine hearing exam*
  - *Hearing aids*
  - *Fitting/evaluation for hearing aids*

## Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is $4,900.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $4,900, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

## Section 1.4 Our plan does not allow providers to "balance bill" you

As a member of Vantage STANDARD (HMO-POS), an important protection for you is that after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a prior authorization or for emergencies or urgently needed services.)
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a prior authorization, or for emergencies or urgently needed services.)

- If you believe a provider has "balance billed" you, call Member Services.

## SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

### Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Vantage STANDARD (HMO-POS) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services from in-network providers that need approval in advance are marked in the Medical Benefits Chart in italics.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling

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

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart.

## Medical Benefits Chart

**AHN Network** - Cost sharing amounts are based on the provider's network. This plan has an Affinity Health Network ("AHN network") in addition to a standard Vantage network ("standard network"). Cost share will be lower if the provider delivering certain services is in the AHN network. Providers in the AHN network are listed on the website and in the *Provider Directory* in a section designated as "Affinity Health Network."

**Out-of-network (OON)/Point-of-Service (POS) benefits** - All services obtained from out-of-network providers require prior authorization (except emergency services, supplemental dental services, supplemental vision services, supplemental hearing services, and urgently needed care when the network is not available or dialysis outside the plan's service area).

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Abdominal aortic aneurysm screening**<br>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors. | **In-Network**<br>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Acupuncture for chronic low back pain**<br>Covered services include:<br>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:<br>For the purpose of this benefit, chronic low back pain is defined as:<br>• Lasting 12 weeks or longer;<br>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.);<br>• not associated with surgery; and<br>• not associated with pregnancy.<br>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.<br>Treatment must be discontinued if the patient is not improving or is regressing.<br>Provider Requirements:<br>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.<br>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:<br>• a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.<br>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Allergy services**<br>You are covered for allergy shots and serum when medically necessary. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Ambulance services**<br>• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. | **In-Network**<br>Emergency Ambulance:<br>$250 copay for each Medicare-covered Ground Ambulance service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>Non-emergency Ambulance:<br>$250 copay for each Medicare-covered Ground Ambulance service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>Emergency Ambulance:<br>$250 copay for each Medicare-covered Ground Ambulance service.*<br><br>Non-emergency Ambulance:<br>Deductible applies.<br>50% coinsurance for each Medicare-covered Ground Ambulance service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. | **In-Network**<br>Emergency Ambulance:<br>20% coinsurance for each Medicare-covered Air Ambulance service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>Non-emergency Ambulance:<br><br>20% coinsurance for each Medicare-covered Air Ambulance service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Emergency Ambulance:<br>20% coinsurance for each Medicare-covered Air Ambulance service.*<br><br>Non-emergency Ambulance:<br>Deductible applies.<br>50% coinsurance for each Medicare-covered Air Ambulance service.*<br>*Prior Authorization is required.* |
| **Annual wellness visit**<br>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once per benefit year.<br>**Note**: Members who are newly enrolled into Medicare are eligible for the "Welcome to Medicare" preventive visit upon enrollment. Existing members are eligible for an annual wellness exam regardless of the date of any prior "Welcome to Medicare" exam. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the annual wellness visit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Bone mass measurement**<br>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. | **In-Network**<br>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Breast cancer screening (mammograms)**<br>Covered services include:<br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram every 12 months for women aged 40 and older<br>• Clinical breast exams once every 24 months<br><br>A screening mammography is used for the early detection of breast cancer in women who have no signs or symptoms of the disease. Once a history of breast cancer has been established, and until there are no longer any signs or symptoms of breast cancer, ongoing mammograms are considered diagnostic and are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. Therefore, the screening mammography annual benefit is not available for members who have signs or symptoms of breast cancer. | **In-Network**<br>There is no coinsurance, copayment, or deductible for covered screening mammograms.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Cardiac rehabilitation services**<br>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. | **In-Network**<br>$40 copay in all outpatient settings for each non-intensive Medicare-covered cardiac rehabilitation service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.<br><br>*Cardiac (heart) rehab services are limited to a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks. Intensive cardiac rehab services are limited to 72 one-hour sessions up to six sessions per day, over a period of up to 18 weeks.* | **In-Network**<br>$60 copay in all outpatient settings for each intensive Medicare-covered cardiac rehabilitation service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)**<br>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Cardiovascular disease testing**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | **In-Network**<br>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>• For all women: Pap tests and pelvic exams are covered once every 24 months<br>• If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months | **In-Network**<br>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Chiropractic services**<br>Covered services include:<br>• We cover only manual manipulation of the spine to correct subluxation (when 1 or more of the bones of your spine move out of position)<br><br>Other services performed by a chiropractor are not covered. | **In-Network**<br>$20 copay per visit<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Colorectal cancer screening**<br>For people 50 and older, the following are covered:<br>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months<br>One of the following every 12 months:<br>• Guaiac-based fecal occult blood test (gFOBT)<br>• Fecal immunochemical test (FIT)<br>DNA based colorectal screening every 3 years<br>For people at high risk of colorectal cancer, we cover:<br>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months<br>For people not at high risk of colorectal cancer, we cover:<br>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy | **In-Network**<br>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| Medicare-covered Barium Enema Preventive Services | **In-Network**<br>$0 copay for each Medicare-covered service.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Dental services**<br>In general, preventive dental services (such as cleaning, routine dental exams, fluoride treatment and dental x-rays) are not covered by Original Medicare.<br>We cover:<br>**Preventive dental services**<br>Up to a $400 maximum benefit coverage amount for all in-network and out-of-network covered services every year. You may be balance-billed by out-of-network providers. | |
| • **Oral Exams**<br>Limited to 1 oral exam(s) every six months<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br>**Out-of-Network**<br>$0 copay* |
| • **Prophylaxis (Cleaning)**<br>Limited to 1 cleaning(s) every six months<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br>**Out-of-Network**<br>$0 copay* |
| • **Dental X-rays**<br>Limited to 1 x-ray(s) 1 bitewing x-ray per year. 1 full mouth x-ray every 3 years. These services share visit frequency of 1.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br>**Out-of-Network**<br>$0 copay* |
| • **Fluoride Treatment**<br>Limited to 1 fluoride treatment(s) every six months<br>Limited to members 22 and younger<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br>**Out-of-Network**<br>$0 copay* |
| **Comprehensive dental services**<br>Up to a $1,500 maximum benefit coverage amount for all in-network and out-of-network covered services every year.You may be balance-billed by out-of-network providers. | |
| • **Non-routine services**<br>Unlimited non-routine services every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br>**Out-of-Network**<br>$0 copay* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • **Diagnostic Services**<br>Unlimited diagnostic services every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Restorative Services**<br>Unlimited restorative services every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Endodontics**<br>Unlimited endodontic services every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Periodontics**<br>Unlimited periodontic services every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Extractions**<br>Unlimited extractions every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services**<br>Unlimited services every year<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| **Medicare-covered comprehensive dental services**<br>Limited Medicare-covered dental services do not include services in connection with preventive care, treatment, filling, removal, or replacement of teeth. Limited Medicare-covered dental services do include dental services by a contracted specialist, such as an oral surgeon. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Depression screening**<br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. | **In-Network**<br>There is no coinsurance, copayment, or deductible for an annual depression screening visit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Diabetes screening**<br>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.<br>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Diabetes self-management training, diabetic services, and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include:<br>• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.<br>**Diabetic supplies are limited to Glucocard Shine strips (50 count) and Glucocard Shine meters manufactured by Arkray USA. All other brands of diabetic supplies require prior authorization.** | **In-Network**<br>Arkray brand/Preferred Pharmacies:<br>0% coinsurance for each Medicare-covered service.<br><br>All other brands/pharmacies:<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Diabetes self-management training is covered under certain conditions. Limited to:<br>○ Initial year: Up to 10 hours of initial training within a continuous 12-month period.<br>○ Subsequent years: Up to 2 hours of follow-up training each calendar year after completing the initial 10 hours of training. | **In-Network**<br>AHN network:<br>0% coinsurance for each Medicare-covered service.<br><br>Standard network:<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Durable medical equipment (DME) and related supplies**<br>(For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.)<br>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.<br><br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.VantageMedicare.com. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.*<br><br>Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month of the 36-month rental period. When equipment has reached its reasonable useful lifetime (usually 5 years), your cost-sharing for equipment rental will resume and start a new 36-month rental period with 20% coinsurance.<br>If prior to enrolling in Vantage STANDARD (HMO-POS) you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in Vantage STANDARD (HMO-POS) is $0 for rental of the oxygen equipment and 20% coinsurance for oxygen contents, repairs, and maintenance. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Emergency care**<br>Emergency care refers to services that are:<br>• Furnished by a provider qualified to furnish emergency services, and<br>• Needed to evaluate or stabilize an emergency medical condition.<br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.<br>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost sharing you would pay at a network hospital.<br>Emergency coverage is worldwide, but the copay is not waived if admitted to a hospital outside of the United States. If you have an emergency outside of the U.S. and its territories, you may be responsible for payment at the time services are rendered. You must submit a claim for reimbursement. For more information please see Chapter 7. You are responsible for any costs exceeding our allowed amount as well as any applicable member cost-share. | $90 copay for emergency room visit.<br>Physician and Professional services: $0 copay<br>You pay these amounts until you reach the out-of-pocket maximum.<br>Copay is waived if you are admitted to a hospital within 72 hours. |
| **Enhanced disease management**<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>Not covered |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Fitness program**<br>Vantage Health Plan offers a fitness benefit for Medicare members by providing access to hundreds of fitness locations throughout the state of Louisiana and thousands more nationwide.<br>The Silver&Fit is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, the Silver&Fit logo and ASHConnected are trademarks of ASH and used with permission herein.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>Not covered |
| **Health and wellness education programs**<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>Not covered |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Hearing services**<br>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.<br><br>Examples of appropriate reasons for ordering diagnostic hearing and balance evaluations that could be covered include, but are not limited to:<br><br>• Evaluation of suspected change in hearing, tinnitus, or balance<br>• Evaluation of the cause of disorders of hearing, tinnitus, or balance<br>• Determination of the effect of medication, surgery, or other treatment<br>• Reevaluation to follow-up changes in hearing, tinnitus, or balance that may be caused by established diagnoses that place you at probable risk for a change in status<br>• Failure of a screening test (although the screening test is not covered)<br>• Diagnostic analysis of cochlear or brainstem implant and programming<br>• Diagnostic hearing and balance evaluations before and periodically after implantation of auditory prosthetic devices | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Additional routine hearing exams**<br>Limited to 1 visit(s) every year<br>You may be balance-billed by out-of-network providers.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Fitting-evaluation(s) for hearing aids**<br>Limited to 1 visit(s) every year<br>You may be balance-billed by out-of-network providers.<br>Please contact the plan for more details.<br><br>**Hearing aids**<br>Up to a $1,100 maximum benefit coverage amount for both ears combined every year for all in-network and out-of-network covered services. You may be balance-billed by out-of-network providers.<br>• **All types**<br>Unlimited hearing aids every year up to maximum benefit coverage amount. Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay*<br>NOTE: Fitting/evaluation is included in hearing aid maximum benefit.<br><br>**In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| **HIV screening**<br>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:<br>• One screening exam every 12 months<br>For women who are pregnant, we cover:<br>• Up to three screening exams during a pregnancy | **In-Network**<br>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Home health agency care**<br>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>Covered services include, but are not limited to:<br>• 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)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services<br>• Medical equipment and supplies | **In-Network**<br>$0 copay for each Medicare-covered service.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Home infusion therapy**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).<br>Covered services include, but are not limited to:<br>• Professional services, including nursing services, furnished in accordance with the plan of care<br>• Patient training and education not otherwise covered under the durable medical equipment benefit<br>• Remote monitoring<br>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| **Hospice care**<br>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<br>Covered services include:<br>• Drugs for symptom control and pain relief<br>• Short-term respite care<br>• Home care | When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Vantage STANDARD (HMO-POS).<br>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Hospice care (continued)**<br>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.<br>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.<br>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).<br>• If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services<br>• If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare)<br>For services that are covered by Vantage STANDARD (HMO-POS) but are not covered by Medicare Part A or B: Vantage STANDARD (HMO-POS) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. | |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice).*<br><br>**Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.<br><br>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | Physician service cost sharing may apply for hospice consultation services. See the "Physician/ Practitioner Services" section of this chart for information on cost-sharing. |
| **Immunizations**<br><br>Covered Medicare Part B services include:<br>• Pneumonia vaccine<br>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary<br>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B<br>• COVID-19 vaccine<br>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules<br><br>We also cover some vaccines under our Part D prescription drug benefit, such as those that help prevent hepatitis A, measles, mumps, rabies, tetanus, and herpes zoster (shingles). Our plan covers most Part D vaccines at no cost to you. Contact plan for details.<br><br>*Prior Authorization is required.* | **In-Network**<br>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Inpatient hospital care**<br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.<br>Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, cost-sharing applies each time you are admitted to the hospital. A transfer to a separate facility type (including Inpatient Rehabilitation, Long Term Acute Care Hospital, Inpatient Acute, or Inpatient Psychiatric facilities) is considered a new admission.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>Covered services include but are not limited to:<br>• Semi-private room (or a private room if medically necessary)<br>• Meals including special diets<br>• Regular nursing services<br>• Costs of special care units (such as intensive care or coronary care units)<br>• Drugs and medications<br>• Lab tests<br>• X-rays and other radiology services<br>• Necessary surgical and medical supplies<br>• Use of appliances, such as wheelchairs<br>• Operating and recovery room costs<br>• Physical, occupational, and speech language therapy<br>• Inpatient substance abuse services | **In-Network**<br>$270 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care.<br>$0 copay for an additional Medicare-covered 60 lifetime reserve days.<br>Cost shares are applied starting on the first day of admission and do not include the day of discharge.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Inpatient hospital care (continued)**<br><br>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.<br><br>Transplant providers may be local or outside of the service area.<br>• If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate.<br>• If the service is available locally but our in-network transplant services are outside the pattern of care for transplants in your community and we require you to obtain transplants at this distant location which causes you to travel, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Such costs will be paid in accordance with the applicable transplant contract.<br>• If the service is only available outside your local area, regardless if that provider is in-network or out-of-network, you will be responsible for any and all travel and lodging expenses.<br>• If the service is available locally by an in-network provider but you choose to use a provider outside your local area, regardless if that provider is in-network or out-of-network, you will be responsible for any and all travel and lodging expenses.<br>While you are receiving care at the distant location, we will also reimburse transportation costs to and from the hospital or doctor's office for evaluations, transplant services and follow-up care. (Transportation in the distant location includes, but is not limited to: vehicle mileage, economy/coach airfare, taxi fares, or rideshare services.) Costs for lodging or places to stay such as hotels, motels or short-term housing as a result of travel for a covered organ transplant may also be covered. You can be reimbursed for eligible costs up to $125 per day total. Transportation services are not subject to the daily limit amount. | If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered hospital stay.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Blood - including storage and administration. All components of blood are covered beginning with the first pint used.<br>• Physician services<br><br>**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.<br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | **In-Network**<br>Outpatient observation cost-sharing is explained in Outpatient Hospital Observation.<br><br>**Out-of-Network**<br>Outpatient observation cost-sharing is explained in Outpatient Hospital Observation. |
| **Inpatient services in a psychiatric hospital**<br>Covered services include mental health care services that require a hospital stay.<br>Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.)<br>For inpatient services in a psychiatric hospital, cost-sharing applies each time you are admitted to the hospital. A transfer to a separate facility type (including Inpatient Rehabilitation, Long Term Acute Care Hospital, Inpatient Acute, or Inpatient Psychiatric facilities) is considered a new admission.<br>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. | **In-Network**<br>$467 copay each day for days 1 to 4 and $0 copay each day for days 5 to 90 for Medicare-covered hospital care.<br>$0 copay for an additional Medicare-covered 60 lifetime reserve days. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| | Cost shares are applied starting on the first day of admission and do not include the day of discharge.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered hospital stay.*<br>*Prior Authorization is required.* |
| **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay**<br>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: | When your stay is no longer covered, these services will be covered with prior authorization as described in the following sections: |
| • Physician services | **In-Network**<br>20% coinsurance for Medicare-covered physician services<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer below to Physician/Practitioner Services, Including Doctor's Office Visits. |
| • Diagnostic tests (like lab tests) | **In-Network**<br>20% coinsurance for Medicare-covered lab services<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • X-ray, radium, and isotope therapy including technician materials and services | **In-Network**<br>20% coinsurance for Medicare-covered x-rays, therapeutic radiology, and diagnostic radiology<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |
| • Surgical dressings | **In-Network**<br>20% coinsurance for Medicare-covered surgical dressings<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |
| • Splints, casts and other devices used to reduce fractures and dislocations | **In-Network**<br>20% coinsurance for Medicare-covered splints, casts, and other devices<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |
| • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices | **In-Network**<br>20% coinsurance for Medicare-covered prosthetic and orthotic devices, repairs and replacements<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer to Prosthetic Devices and Related Supplies. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition | **In-Network**<br>20% coinsurance for Medicare-covered leg, arm, back, and neck braces, repairs and replacements<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer to Prosthetic Devices and Related Supplies. |
| • Physical therapy, speech therapy, and occupational therapy | **In-Network**<br>20% coinsurance for Medicare-covered physical therapy, speech therapy, and occupational therapy<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Please refer below to Outpatient Rehabilitation Services. |
| **Medical nutrition therapy**<br>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.<br>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. | **In-Network**<br>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Medicare Diabetes Prevention Program (MDPP)**<br>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.<br>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the MDPP benefit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Medicare Part B prescription drugs**<br>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:<br>• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services<br>• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan<br>• Clotting factors you give yourself by injection if you have hemophilia<br>• Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant<br>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug | **In-Network**<br>20% coinsurance for other Part B-covered drugs in all outpatient settings, including specialty drugs.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| • Antigens<br>• Certain oral anti-cancer drugs and anti-nausea drugs<br>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Aranesp®)<br>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br><br>We also cover some vaccines under our Part B and Part D prescription drug benefit. Our plan covers most Part D vaccines at no cost to you.<br><br>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. | **In-Network**<br>20% coinsurance for Part B-covered chemotherapy drugs in all outpatient settings.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Obesity screening and therapy to promote sustained weight loss**<br><br>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. | **In-Network**<br>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| **Opioid treatment program services**<br>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:<br>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.<br>• Dispensing and administration of MAT medications (if applicable)<br>• Substance use counseling<br>• Individual and group therapy<br>• Toxicology testing<br>• Intake activities<br>• Periodic assessments | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Outpatient diagnostic tests and therapeutic services and supplies**<br>Covered services include, but are not limited to:<br>• X-rays | **In-Network**<br>$0 copay for Medicare-covered Physician services<br>20% coinsurance for Medicare-covered facility services in outpatient hospital settings.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| • Radiation (radium and isotope) therapy including technician materials and supplies | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Surgical supplies, such as dressings<br>• Splints, casts, and other devices used to reduce fractures and dislocations | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Laboratory tests (genetic testing/gene analysis requires prior authorization) | **In-Network**<br>$0 copay for each Medicare-covered service.<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Other outpatient diagnostic tests - Non-radiological diagnostic services | **In-Network**<br>0% coinsurance for Medicare-covered Physician services.<br>20% coinsurance for Medicare-covered facility services in outpatient hospital settings.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| • Other outpatient diagnostic tests - Radiological diagnostic services such as: Diagnostic Mammograms, Bone Scan, Cardiac Stress Test, CT Scan, Echocardiogram, EEG, EMG, Event Monitor, HIDA Scan, Holter Monitor, MRI, Nerve Conduction Study, Nuclear Cardiac Stress Test, PET Scan, Pulmonary Function Test, and Sleep Study. | **In-Network**<br>AHN network:<br>$100 copay<br>Standard network:<br>$150 copay<br>You pay these amounts until you reach the out-of-pocket maximum.<br>$0 copay for Medicare-covered diagnostic mammograms<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.*<br><br>If an office visit is billed on same date of service as the procedure/test, the applicable office visit copay also applies. |
| • Diagnostic colonoscopies | **In-Network**<br>$0 copay for each Medicare-covered service.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| **Outpatient hospital observation**<br>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.<br><br>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<br><br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.<br><br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | **In-Network**<br>$0 copay for Medicare-covered Physician services.<br>$270 copay per day for each Medicare-covered facility service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Outpatient hospital services**<br>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br><br>Covered services include, but are not limited to:<br><br>• Services in an emergency department | **In-Network**<br>Please refer to Emergency Care.<br><br>**Out-of-Network**<br>Please refer to Emergency Care. |

| Services that are covered for you | What you must pay when you get these services |
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| • Services performed at an outpatient clinic | **In-Network**<br>Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.<br><br>**Out-of-Network**<br>Please refer to Physician/Practitioner Services, Including Doctor's Office Visits. |
| • Outpatient surgery or observation | **In-Network**<br>Please refer to Outpatient Hospital Observation and Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.<br><br>**Out-of-Network**<br>Please refer to Outpatient Hospital Observation and Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers. |
| • Laboratory and diagnostic tests billed by the hospital (genetic testing/gene analysis requires prior authorization) | **In-Network**<br>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.<br><br>**Out-of-Network**<br>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |
| • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it | **In-Network**<br>Please refer to Outpatient Mental Health Care.<br><br>**Out-of-Network**<br>Please refer to Outpatient Mental Health Care. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • X-rays and other radiology services billed by the hospital | **In-Network**<br>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.<br><br>**Out-of-Network**<br>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |
| • Medical supplies such as splints and casts | **In-Network**<br>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.<br><br>**Out-of-Network**<br>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies. |
| • Certain drugs and biologicals that you can't give yourself<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.<br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | **In-Network**<br>Please refer to Medicare Part B Prescription Drugs.<br><br>**Out-of-Network**<br>Please refer to Medicare Part B Prescription Drugs. |

| Services that are covered for you | What you must pay when you get these services |
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| **Outpatient mental health care**<br>Covered services include:<br>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Cost share for Medicare-covered outpatient group and individual therapy visit applies to facility and professional claims separately. | |
| • Services provided by a psychiatrist | **In-Network**<br>AHN network:<br>$0 copay for each Medicare-covered Individual Session.<br><br>Standard network:<br>$30 copay for each Medicare-covered Individual Session.<br><br>AHN network:<br>$0 copay for each Medicare-covered Group Session.<br><br>Standard network:<br>$30 copay for each Medicare-covered Group Session.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Services provided by other mental health care providers | **In-Network**<br>AHN network:<br>$0 copay for each Medicare-covered Individual Session.<br><br>Standard network:<br>$30 copay for each Medicare-covered Individual Session.<br><br>AHN network:<br>$0 copay for each Medicare-covered Group Session.<br><br>Standard network:<br>$30 copay for each Medicare-covered Group Session.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Outpatient rehabilitation services**<br>Covered services include: physical therapy, occupational therapy, and speech language therapy.<br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).<br><br>NOTE: Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day. | |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Services provided by a physical therapist or speech language therapist | **In-Network**<br>AHN network:<br>$0 copay for each Medicare-covered visit in all outpatient settings.<br><br>Standard network:<br>$10 copay for each Medicare-covered visit in all outpatient settings.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Services provided by an occupational therapist | **In-Network**<br>AHN network:<br>$0 copay for each Medicare-covered visit in all outpatient settings.<br><br>Standard network:<br>$10 copay for each Medicare-covered visit in all outpatient settings.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Outpatient substance abuse services**<br>Covered services include:<br>• Individual substance abuse outpatient treatment<br>• Group substance abuse outpatient treatment<br>Coverage is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The services must also be reasonable and necessary for treatment of the individual's condition, limited to Original Medicare guidelines. Cost share for Medicare-covered individual or group visits applies to both facility and professional services separately. | **In-Network**<br>AHN network:<br>$0 copay for each Medicare-covered Individual Session.<br><br>Standard network:<br>$30 copay for each Medicare-covered Individual Session.<br><br>AHN network:<br>$0 copay for each Medicare-covered Group Session.<br><br>Standard network:<br>$30 copay for each Medicare-covered Group Session.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br>**Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." | |
| • Services provided at an outpatient hospital | **In-Network**<br>AHN network:<br>$150 copay<br><br>Standard network:<br>$250 copay<br>$0 copay for Medicare-covered diagnostic colonoscopies.<br>$0 copay for Physician services<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Services provided at an ambulatory surgical center | **In-Network**<br>$250 copay<br>You pay these amounts until you reach the out-of-pocket maximum.<br>$0 copay for Medicare-covered diagnostic colonoscopies.<br>$0 copay for Physician services<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Over-the-counter benefit**<br>You are eligible for up to $100 maximum benefit coverage amount every three months.<br>The quarterly allowance (January, April, July and October) will be loaded onto your Flex card to purchase a wide range of health-related products. The quarterly allowance expires at the end of each quarter (March 31st, June 30th, September 30th and December 31st).<br>Unused funds do not roll over to the next period.<br>You can use your Flex card to purchase OTC items at participating nationwide chain retailers and many local independent merchants and pharmacies.<br>You can also use your Flex card to order OTC items by phone or online and have them delivered to your home. To place your order by phone, call Saint John Pharmacy OTC Mail Order (833) 373-3682 or Vantage OTC Mail Order at (833) 952-2771. To place your order online, log in to your Vantage Member Portal (members.vantagehealthplan.com) and click the Vantage Flex link. Once your OTC order is made, please allow 10-14 days for your order to be delivered. Shipping, handling and taxes are all included in the price of your items.<br>You can also use the Vantage Member Portal to view balances, search for retail locations, and view transactions.<br>OTC mail order is limited to products available on our over-the-counter mail order list which includes: | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>Not covered |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Minerals and vitamins<br>• Fiber supplements<br>• First aid supplies<br>• Medicines and ointments, such as antacids, analgesics, antibacterials, and anti-inflammatories<br>• Mouth care, such as toothbrushes, toothpaste, and denture adhesives<br><br>Purchase total(s) may not exceed the allowance for each quarter and are applied to the quarterly period in which the purchase occurred. Items and price per item are subject to change. If you terminate coverage with the Plan, the OTC benefit terminates automatically.<br><br>Please call Member Services at (833) 952-2771, Monday - Friday, 7 a.m.-7 p.m. (CST) for more information about your Flex card or if you have issues using it.<br><br>PayForward LLC is an independent company that administers the prepaid Flex Card benefits for Vantage Medicare Advantage plans.<br><br>Please contact the plan for more details. | |
| **Pain management services** | **In-Network**<br>20% coinsurance for Physician services<br>$250 copay in an outpatient hospital<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Partial hospitalization services**<br>"Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. These services include intensive outpatient programs (IOPs). | **In-Network**<br>$55 copay per day for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance per day for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Personal emergency response system (PERS)**<br>MobileHelp® Personal Emergency Response System gives the member peace of mind knowing that emergency help is just a button press away. The medical alert system can summon help at home and away from home.<br>*MobileHelp is a registered trademark of MobileHelp. Patented technology. MobileHelp is an FDA-registered Medicare Device Manufacturer.*<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>Not covered |
| **Physician/Practitioner services, including doctor's office visits**<br>Covered services include:<br>• Office visit (includes medically-necessary medical care or surgery services furnished in a physician's office by a primary care provider) | **In-Network**<br>$0 copay for each Medicare-covered service.<br><br>**Out-of-Network**<br>Deductible may apply.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Medically-necessary medical care or surgery services furnished in a certified ambulatory surgical center or hospital outpatient department | **In-Network**<br>See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.<br><br>**Out-of-Network**<br>See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting. |
| • Consultation, diagnosis, and treatment by a specialist | **In-Network**<br>AHN network:<br>$35 copay for each Medicare-covered service.<br><br>Standard network:<br>$45 copay for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Other health care professionals - Includes Physician Assistants (PAs) and Nurse Practitioners (NPs) | **In-Network**<br>AHN network:<br>$0 copay - $35 copay depending on the Medicare-covered service and provider type.<br><br>Standard network:<br>$0 copay - $45 copay depending on the Medicare-covered service and provider type.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment | **In-Network**<br>See “Hearing Services” in this chart for any applicable cost share amounts.<br><br>**Out-of-Network**<br>See "Hearing Services" in this chart for any applicable cost share amounts. |
| • Certain telehealth services, including: consultation, diagnosis, and treatment for Medicare covered Part B services furnished through electronic exchange when a PCP or Specialist is not in the same location as the member (within the United States), including the member’s home. Your plan also covers Dietician, Outpatient Mental Health, Outpatient Substance Abuse, Podiatry, Occupational, Physical, and Speech therapy provider services via telehealth.<br>○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider | **In-Network**<br>Primary care visits<br>$0 copay<br><br>Specialist visits<br>AHN network:<br>$35 copay<br>Standard network:<br>$45 copay |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| who offers the service by telehealth.<br>○ Available means of electronic exchange include:<br>• Audio and visual communication<br>• Audio only (telephone or other communication device)<br>• E-visit through a provider's online portal, if available. | Other health care professionals:<br>AHN network:<br>Primary Care Providers: $0 copay<br>Specialist: $35 copay<br>Standard network:<br>Primary Care Providers: $0 copay<br>Specialist: $45 copay<br><br>Dietician:<br>AHN network: $0 copay<br>Standard network: 20% coinsurance<br><br>Mental Health and Psychiatric provider:<br>AHN network: $0 copay<br>Standard network: $30 copay<br><br>Substance Abuse provider:<br>AHN network: $0 copay<br>Standard network: $30 copay<br><br>Podiatry services:<br>AHN network: $35 copay<br>Standard network: $45 copay<br><br>Occupational, physical, and speech therapy services:<br>AHN network: $0 copay<br>Standard network: $10 copay<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>**Out-of-Network**<br>Not covered |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare | **In-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |
| • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home | **In-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Telehealth services to diagnose, evaluate, or treat symptons of a stroke, regardless of your location | **In-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |
| • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location | **In-Network**<br>You will pay the cost-sharing that applies to substance abuse services (as described under "Outpatient substance abuse services" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to substance abuse services (as described under "Outpatient substance abuse services" above). |
| • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>○ You have an in-person visit within 6 months prior to your first telehealth visit<br>○ You have an in-person visit every 12 months while receiving these telehealth services<br>○ Exceptions can be made to the above for certain circumstances | **In-Network**<br>You will pay the cost-sharing that applies to mental health services (as described under "Outpatient mental health care" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to mental health services (as described under "Outpatient mental health care" above). |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers | **In-Network**<br>You will pay the cost-sharing that applies to mental health services (as described under "Outpatient mental health care" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to mental health services (as described under "Outpatient mental health care" above). |
| • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:<br>○ You're not a new patient **and**<br>○ The check-in isn't related to an office visit in the past 7 days **and**<br>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment | **In-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |
| • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:<br>○ You're not a new patient **and**<br>○ The evaluation isn't related to an office visit in the past 7 days **and**<br>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment | **In-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Consultation your doctor has with other doctors by phone, internet, or electronic health record | **In-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |
| • Second opinion by another network provider prior to surgery | **In-Network**<br>You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).<br><br>**Out-of-Network**<br>You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). |
| • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Podiatry services**<br>Covered services include:<br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)<br>• Routine foot care for members with certain medical conditions affecting the lower limbs | **In-Network**<br>AHN network:<br>$35 copay in all outpatient settings<br><br>Standard network:<br>$45 copay in all outpatient settings<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Prostate cancer screening exams**<br>For men aged 50 and older, covered services include the following - once every 12 months:<br>• Digital rectal exam | **In-Network**<br>$0 copay for each Medicare-covered service.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Prostate Specific Antigen (PSA) test | **In-Network**<br>There is no coinsurance, copayment, or deductible for an annual PSA test.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Prosthetic devices and related supplies**<br>Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Pulmonary rehabilitation services**<br>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. | **In-Network**<br>$20 copay for each Medicare-covered service in all outpatient settings.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Screening and counseling to reduce alcohol misuse**<br>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.<br>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br>For qualified individuals, a LDCT is covered every 12 months.<br>**Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.<br>*For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.<br>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
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| **Services to treat kidney disease**<br>Covered services include: | |
| • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area:<br>20% coinsurance for each Medicare-covered service.*<br>All other out-of-network providers:<br>Deductible applies.<br>20% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) | **In-Network**<br>Please refer to Inpatient Hospital Care.<br><br>**Out-of-Network**<br>Please refer to Inpatient Hospital Care. |
| • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • Home dialysis equipment and supplies | **In-Network**<br>Please refer to Durable Medical Equipment and Related Supplies.<br><br>**Out-of-Network**<br>Please refer to Durable Medical Equipment and Related Supplies. |
| • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) | **In-Network**<br>Please refer to Home Health Agency Care.<br><br>**Out-of-Network**<br>Please refer to Home Health Agency Care. |
| Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.” | |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Skilled nursing facility (SNF) care**<br>(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.")<br>You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.<br>A 3-day prior hospital stay is required.<br>Covered services include but are not limited to:<br>• Semiprivate room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Skilled nursing services<br>• Physical therapy, occupational therapy, and speech therapy<br>• Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)<br>• Blood - including storage and administration. All components of blood are covered beginning with the first pint used.<br>• Medical and surgical supplies ordinarily provided by SNFs<br>• Laboratory tests ordinarily provided by SNFs<br>• X-rays and other radiology services ordinarily provided by SNFs<br>• Use of appliances such as wheelchairs ordinarily provided by SNFs<br>• Physician/Practitioner services<br>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.<br>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)<br>• A SNF where your spouse is living at the time you leave the hospital | **In-Network**<br>$0 copay each day for days 1 to 20 and $188 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care.<br>A benefit period begins on the first day you go into a Medicare-covered skilled nursing facility. The benefit period ends when you have not received any inpatient skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Cost shares are applied starting on the first day of admission and do not include the day of discharge.<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered skilled nursing facility stay.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.<br>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Supervised Exercise Therapy (SET)**<br>SET is covered for members who have symptomatic peripheral artery disease (PAD).<br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<br>The SET program must:<br>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication<br>• Be conducted in a hospital outpatient setting or a physician's office<br>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD<br>• Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques<br>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. | **In-Network**<br>AHN network:<br>$0 copay per session<br><br>Standard network:<br>$10 copay per session<br>You pay these amounts until you reach the out-of-pocket maximum.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Transportation**<br>Routine transportation for up to 24 trips every year.<br>A trip is considered one-way transportation by van or medical transport to a plan-approved health-related location.<br>Please contact the plan for more details.<br>Call 1-844-657-7820 or TTY users should call 711 to schedule transportation.<br>**Some restrictions apply.** | **In-Network**<br>$0 copay*<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Not covered |
| **Urgently needed services**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network.<br>Coverage is limited to the United States and its territories. | $60 copay for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Vision care**<br>Covered services include: | |
| • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts; however, this plan does cover routine eye exams. See below. | **In-Network**<br>AHN network:<br>$35 copay for each Medicare-covered service.<br><br>Standard network:<br>$45 copay for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older | **In-Network**<br>$0 copay for each Medicare-covered service.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| • For people with diabetes, screening for diabetic retinopathy is covered once per year | **In-Network**<br>$0 copay for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare. Any upgrades are not covered (included, but not limited to, deluxe frames, tinting, progressive lenses, or anti-reflective coating). | **In-Network**<br>20% coinsurance for each Medicare-covered service.<br>You pay these amounts until you reach the out-of-pocket maximum.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.*<br><br>To receive Medicare-covered eyewear, the provider must be a Medicare-approved supplier. |
| • **Routine eye exam**<br>Limited to 1 visit(s) every year<br>Please contact the plan for more details.<br><br>NOTE: You are covered for either a routine eye exam or a diabetic eye exam from in-network or out-of-network providers. You may be balance-billed by out-of-network providers.<br><br>**Supplemental eyewear**<br><br>Up to a $300 combined credit every year for all additional eyewear from in-network and out-of-network providers and retailers. The eyewear allowance is loaded onto your Flex card every year and does not carry over to the next year. Use your Flex card at a participating eyewear provider, nationwide chain retailer, or a local independent merchant. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>50% coinsurance* |
| • **Contact lenses**<br>Limited to 12 pair(s) of contact lenses every year.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Eyeglass frames**<br>Limited to 1 pair(s) of eyeglass frames every year.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • **Eyeglass lenses**<br>Limited to 1 set(s) of eyeglass lenses every year.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Eyeglasses (lenses and frames)**<br>Limited to 1 pair(s) of eyeglasses (lenses and frames) every year.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| • **Upgrades**<br>Eyewear upgrades are available.<br>Please contact the plan for more details. | **In-Network**<br>$0 copay*<br><br>**Out-of-Network**<br>$0 copay* |
| **"Welcome to Medicare" preventive visit**<br>The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.<br>**Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit. | **In-Network**<br>There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |
| **Other Medicare-covered preventive services**<br><br>• Medicare-covered EKG following "Welcome to Medicare" preventive visit | **In-Network**<br>$0 copay for each Medicare-covered service.<br><br>**Out-of-Network**<br>Deductible applies.<br>50% coinsurance for each Medicare-covered service.*<br>*Prior Authorization is required.* |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Worldwide emergency coverage**<br>You are covered for emergency care worldwide, but the copay is not waived if admitted to a hospital outside the United States. If you have an emergency out of the U.S. and its territories, you will be responsible for payment at the time services are rendered. You must submit a claim for reimbursement. For more information, please see Chapter 7. You are responsible for any costs exceeding our allowed amount as well as any applicable member cost-share.<br>Please contact the plan for more details. | $90 copay* |

## SECTION 3 What services are not covered by the plan?

### Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Services considered not reasonable and necessary, according to Original Medicare standards | | √<br>Dental, vision, transportation, OTC, hearing exam, hearing aids, exam to fit hearing aids, certain telehealth services, and a fitness program are covered only to the extent of the benefits as listed in Section 2.1 of this chapter. |
| Experimental medical and surgical procedures, equipment, and medications.<br>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community. | | √<br>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.<br>(See Chapter 3, Section 5 for more information on clinical research studies.) |
| Surgical treatment for morbid obesity | | √<br>Unless it is considered medically necessary and covered under Original Medicare. |
| Private room in a hospital. | | √<br>Covered only when medically necessary. |
| Private duty nurses | √ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television. | √ | |
| Full-time nursing care in your home. | √ | |
| Custodial care<br><br>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing. | √ | |
| Homemaker services including basic household assistance, such as light housekeeping or light meal preparation. | √ | |
| Fees charged for care by your immediate relatives or members of your household. | √ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance) | | √<br>Covered only when medically necessary. |
| Cosmetic surgery or procedures, including but not limited to beauty salon services, such as pedicures and manicures. | | √<br>• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.<br>• Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance. |
| Dental care, such as cleanings, fillings, dentures, x-rays, oral exams, fluoride treatment or comprehensive dental services | | √<br>Covered only to the extent of the maximum benefit listed as Dental services in Section 2.1 of this chapter. |
| Sealants and orthodontia | √ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Non-routine dental care | | √<br>Dental care required to treat illness or injury may be covered as inpatient or outpatient care. |
| Routine chiropractic care | | √<br>Manual manipulation of the spine to correct a subluxation is covered. |
| Routine foot care | | √<br>Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). |
| Home-delivered meals | √ | |
| Orthopedic shoes or supportive devices for the feet | | √<br>Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or theraputic shoes for people with diabetic foot disease. |
| Routine hearing exams, hearing aids, or exams to fit hearing aids. | | √<br>Routine hearing exams, hearing aids, and exams to fit hearing aids are covered only to the extent of the maximum benefit listed as Hearing services in Section 2.1 of this chapter. |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Assistive listening devices | √ | |
| Radial keratotomy, LASIK surgery, and other low vision aids. | √ | |
| Routine eye examinations and supplemental eyewear. | | √<br>• Limited to one visit every year for either a routine eye exam or a diabetic eye exam.<br>• Supplemental eyewear is covered at 100% of the allowed amount only to the extent of the maximum benefit listed as Vision care in Section 2.1 of this chapter.<br>• One pair of eyeglasses with standard frames and lenses (or contact lenses) as defined by Medicare are covered for people after cataract surgery. |
| Vision therapy | | √<br>Vision therapy (e.g., ocular exercises, visual training, vision training, orthoptics, and any associated supplemental testing) is not covered unless used as part of the treatment plan for rehabilitation services for members with vision impairment. |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Stand-alone peripherals such as hearing aid batteries and contact lens cases when not factory packaged with the hearing aids or contact lenses, respectively. | √ | |
| Reversal of sterilization procedures and/or non-prescription contraceptive supplies. | √ | |
| Acupuncture | | √<br>Available for people with chronic low back pain under certain circumstances. |
| Massage therapy | √ | |
| Smoke detectors and fire extinguishers | √ | |
| Electronic medical records and electronic data storage devices | √ | |
| Naturopath services (uses natural or alternative treatments). | √ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Transportation | | √<br>Transportation is covered only to the extent of the benefit listed as Transportation in Section 2.1 of this chapter. |
| Over-the-counter (OTC) items | | √<br>OTC items are covered only to the extent of the benefit listed as Over-the-Counter items in Section 2.1 of this chapter. |
| Gym memberships | | √<br>Gym memberships are covered only to the extent of the benefit listed as Health and Wellness in Section 2.1 of this chapter. |
| Professional charges for clinical lab | √ | |
| Personal Emergency Response System (PERS) | | √<br>PERS is covered only to the extent of the benefit listed as PERS in Section 2.1 of this chapter. |
| Erection or contraception devices or systems | √ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Batteries or battery chargers for patient-owned ventilators or power adapters, chargers, and batteries used as alternative power sources for any equipment capable of AC power operation | √ | |
| Items not defined as durable medical equipment, which may include hot water bottles, reaching/grab devices, wigs, exercise equipment, alert or alarm devices, bath/tub/toilet devices, bed table or accessories, whirlpool/hot tub, restraints and safety equipment | √ | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Services billed by various providers not covered by Original Medicare | √<br><br>Provider types include:<br>• Acupuncturist<br>• Assisted Living Facility<br>• Birthing Center<br>• Certified Alcohol and Drug Counselor<br>• Certified Social Worker<br>• Drug and Alcohol Rehabilitation Counselor<br>• Licensed Alcoholic and Drug Counselor<br>• Licensed Massage Therapist<br>• Licensed Practical Nurse<br>• Licensed Professional Counselor<br>• Marriage Family Therapist<br>• Master of Social Work<br>• Mental Health Counselor<br>• National Certified Counselor<br>• Registered Nurse<br>• Substance Abuse Facility | Covered only if billed under a participating physician or other health care professional. |

# CHAPTER 5:

## *Using the plan's coverage for Part D prescription drugs*

## SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

### Section 2.1 Use a network pharmacy

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

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

### Section 2.2 Network pharmacies

#### How do you find a network pharmacy in your area?

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

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

### What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Member Services or use the *Pharmacy Directory*. You can also find information on our website at www.VantageMedicare.com.

### What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note**: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

## Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. Drugs that are limited to a one-month supply for both retail and mail order are marked with an "NDS" ("Non-Extended Day Supply") in our Drug List.

Our plan's mail-order service allows you to order **at least a 31-day supply and up to a 100-day supply of Tier 1 drugs, at least a 63-day supply and up to a 100-day supply of Tier 2, 3, and 4 drugs, and no more than a 31-day supply of Tier 5 drugs.**

This plan offers mail-order benefits with preferred and standard cost-sharing. As shown in the tables in Sections 5.2 and 5.4 of Chapter 6, the preferred mail order copay for Tier 1 Preferred Generic prescription drugs is $0. However, Tier 1 Preferred Generic prescription drugs obtained from any other mail order pharmacy in the plan's network will have the standard Tier 1 $5 or $15 mail order copay applied (depending on the days' supply).

To get information about filling your prescriptions by mail, either download a copy of the form from our website (www.vantagemedicare.com) or call Member Services at 1-318-361-0900 or toll-free 1-866-704-0109, Monday – Friday, 8:00 a.m. – 8:00 p.m. CST. (TTY users should call 711.) Please note that you must use a network mail order pharmacy. If you use a mail order pharmacy not in the plan's

network, your prescription will not be covered.

Usually, a mail order pharmacy order will be delivered to you in no more than 5 to 7 business days. However, sometimes your mail order may be delayed. Should your mail order be delayed, you may call Vantage Health Plan at 1-318-361-0900 or toll-free 1-866-704-0109 (TTY users should call 711) to request authorization to obtain a supply of medication from a retail network pharmacy until your mail order is received.

**New prescriptions the pharmacy receives directly from your doctor's office.**

After the pharmacy receives 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. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

**Refills on mail-order prescriptions.** For refills, please contact your pharmacy 7 to 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost-sharing) at a lower cost-sharing amount. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

### Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If the prescriptions are related to care for a medical emergency or urgently needed care.
- If you are traveling outside of your plan's service area but within the United States and territories and

become ill, or run out of your prescription drugs. If a network pharmacy is not available, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document.

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If the prescription is limited to no more than a 31-day supply or less if written for fewer days, and authorization is obtained prior to purchase.
- If your prescription is for a specialty drug that in-network pharmacies do not usually keep in stock.
- If you are evacuated from your home because of a state, federal, or public health emergency and do not have access to an in-network pharmacy.
- If you get a covered prescription drug from an institutional-based pharmacy while a patient in an emergency room, provider-based clinic, outpatient surgery clinic, or other outpatient setting.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (including high cost and unique drugs).
- If it is one of the covered drugs that can be supplied and administered in the doctor's office.

### How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

The drugs on the Drug List are only those covered under Medicare Part D.

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

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

### What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

## Section 3.2 There are five (5) "cost-sharing tiers" for drugs on the Drug List

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

- Tier 1 includes Preferred Generics and is the lowest tier.
- Tier 2 includes Generics.
- Tier 3 includes Preferred Brand drugs. Select Insulins are also included in this tier.
- Tier 4 includes Non-Preferred Brand drugs. Select Insulins are also included in this tier.
- Tier 5 includes Specialty Tier drugs and is the highest tier. Select Insulins are also included in this tier.

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

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

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

You have three ways to find out:

1. Check the most recent Drug List we provided electronically.

2. Visit the plan's website (www.VantageMedicare.com). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

## SECTION 4 There are restrictions on coverage for some drugs

### Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once on our drug list. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

### Section 4.2 What kinds of restrictions?

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

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** Contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

#### Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider 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 share of the cost may be greater for the brand name drug than for the generic drug.)

#### Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered

by the plan.

### Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

### Quantity limits

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

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

### Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.

- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

### You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

- **If you are a new member,** we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 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. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For members who have a change in level of care (setting):**
  Our plan will cover a temporary 31-day supply of non-formulary drugs (unless the prescription is written for fewer days) one time only for current members with level of care changes. You will pay the cost share amount that applies to Tier 5 drugs for such temporary supplies of non-formulary drugs.
  - A level of care change may include:
    - Entering or leaving a long-term care (LTC) facility
    - Discharged from a hospital to a home
    - End a Medicare Part A skilled nursing facility stay
    - Revoke Hospice status and revert to Original Medicare benefits
    - End a long-term care facility stay and return to their home

  If a member has more than one change in level of care in a month, the pharmacy will have to call Vantage to request an extension of the transition policy.

For questions about a temporary supply, call Member Services.

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

### 1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

### 2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

### You can change to another drug

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

### You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

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

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

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

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

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

#### Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

#### Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell

you right away.

- Your prescriber will also know about this change and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

**Changes to the Drug List that do not affect you during this plan year**

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

In general, changes that will not affect you during the current plan year are:

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

### Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

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

## SECTION 8 Filling a prescription

### Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you

pick up your prescription.

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

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

## SECTION 9 Part D drug coverage in special situations

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

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

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

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

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

#### What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

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

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

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

### Special note about 'creditable coverage':

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

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

**Keep this notice about creditable coverage** because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

# SECTION 10 Programs on drug safety and managing medications

## Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

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

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

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

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

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

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

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

# CHAPTER 6:

*What you pay for your Part D prescription drugs*

### Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services, and ask for the "LIS Rider."

## SECTION 1 Introduction

### Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.

### Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost sharing" and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you pay for drugs before our plan begins to pay its share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost you pay each time you fill a prescription.

### Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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#### These payments <u>are included</u> in your out-of-pocket costs

**<u>Your out-of-pocket costs include</u>** the payments listed below (as long as they are for Part D covered drugs, and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:

- The Deductible Stage
- The Initial Coverage Stage
- The Coverage Gap Stage

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

**It matters who pays:**

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

**Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of $7,400 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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## These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health

programs such as TRICARE and the Veterans Affairs.

- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

  *Reminder:* If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

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### How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $7,400, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

## SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

### Section 2.1 What are the drug payment stages for Vantage STANDARD (HMO-POS) members?

There are four "drug payment stages" for your prescription drug coverage under Vantage STANDARD (HMO-POS). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

**Stage 1: Yearly Deductible Stage**

**Stage 2: Initial Coverage Stage**

**Stage 3: Coverage Gap Stage**

**Stage 4: Catastrophic Coverage Stage**

**Important Message About What You Pay for Insulin -** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

## SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

### Section 3.1 We send you a monthly summary called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket, or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D Explanation of Benefits* ("Part D EOB"). The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

### Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled**. This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.

- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

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

## SECTION 4 During the Deductible Stage, you pay the full cost of your Tier 4 and Tier 5 drugs

The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of $505 on Tier 4 and Tier 5 drugs. **You must pay the full cost of your Tier 4 and Tier 5 drugs** until you reach the plan's deductible amount. For all other drugs, you will not have to pay any deductible. The **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $505 for your Tier 4 and Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

There is no deductible for Vantage STANDARD (HMO-POS) for Select Insulins. During the Deductible Stage, your out-of-pocket costs for these Select Insulins will be $35 for a one-month supply. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by "SI" listed in the Drug List. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).

## SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share

### Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary

depending on the drug and where you fill your prescription.

### The plan has five (5) cost-sharing tiers

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

- Tier 1 includes Preferred Generics and is the lowest tier.
- Tier 2 includes Generics.
- Tier 3 includes Preferred Brand drugs. Select Insulins are also included in this tier.
- Tier 4 includes Non-Preferred Brand drugs. Select Insulins are also included in this tier.
- Tier 5 includes Specialty Tier drugs and is the highest tier. Select Insulins are also included in this tier.

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

### Your pharmacy choices

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

- A network retail pharmacy that offers standard cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers preferred cost sharing
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- A network mail-order pharmacy that offers standard cost-sharing
- The plan's mail order pharmacy that offers preferred cost-sharing

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory.*

## Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

## Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

| | **Standard retail cost-sharing (in-network)** (up to a 31-day supply) | **Preferred retail cost-sharing (in-network)** (up to a 31-day supply) | **Standard mail-order cost-sharing** (up to a 31-day supply) | **Preferred mail-order cost sharing** (up to a 31-day supply) | **Long-term care (LTC) cost-sharing** (up to a 31-day supply) | **Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply) |
|---|---|---|---|---|---|---|
| **Cost-Sharing Tier 1** (Preferred Generics) | $5 copay | $0 copay | $5 copay | $0 copay | $5 copay | $5 copay plus cost differential* |
| **Cost-Sharing Tier 2** (Generics) | $14 copay | $14 copay | Mail order is not available for drugs in Tier 2. | Preferred Mail order is not available for drugs in Tier 2. | $14 copay | $14 copay plus cost differential* |
| **Cost-Sharing Tier 3** (Preferred Brand) | $47 copay<br>$35 copay for select insulins | $47 copay<br>$35 copay for select insulins | Mail order is not available for drugs in Tier 3. | Preferred Mail order is not available for drugs in Tier 3. | $47 copay<br>$35 copay for select insulins | $47 copay plus cost differential*<br>$35 copay for select insulins |
| **Cost-Sharing Tier 4** (Non-Preferred Brand) | $100 copay<br>$35 copay for select insulins | $100 copay<br>$35 copay for select insulins | Mail order is not available for drugs in Tier 4. | Preferred Mail order is not available for drugs in Tier 4. | $100 copay<br>$35 copay for select insulins | $100 copay plus cost differential*<br>$35 copay for select insulins |

| | **Standard retail cost-sharing (in-network)** (up to a 31-day supply) | **Preferred retail cost-sharing (in-network)** (up to a 31-day supply) | **Standard mail-order cost-sharing** (up to a 31-day supply) | **Preferred mail-order cost sharing** (up to a 31-day supply) | **Long-term care (LTC) cost-sharing** (up to a 31-day supply) | **Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply) |
|---|---|---|---|---|---|---|
| **Cost-Sharing Tier 5** (Specialty Tier) | 25% coinsurance $35 copay for select insulins | 25% coinsurance $35 copay for select insulins | 25% coinsurance $35 copay for select insulins | 25% coinsurance $35 copay for select insulins | 25% coinsurance $35 copay for select insulins | 25% coinsurance plus cost differential* $35 copay for select insulins |
| *Cost differential - difference between billed amount and what we normally pay. The copay for Select Insulins will cap at no more than $35 for a one-month supply.<br>To find out which drugs are Select Insulins, review the most recent Drug List or call Member Services. | | | | | | |

## Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. 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 receive.

## Section 5.4 A table that shows your costs for a *long-term* (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 100-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

### Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

| Tier | **Standard retail cost sharing (in-network)** (up to a 100-day supply) | **Preferred retail cost sharing (in-network)** (up to a 100-day supply) | **Standard mail-order cost-sharing** (up to a 100-day supply) | **Preferred mail-order cost sharing** (up to a 100-day supply) |
|---|---|---|---|---|
| **Cost-Sharing Tier 1** (Preferred Generics) | $15 copay | $0 copay | $15 copay | $0 copay |
| **Cost-Sharing Tier 2** (Generics) | $42 copay | $42 copay | $42 copay | $42 copay |
| **Cost-Sharing Tier 3** (Preferred Brand) | $141 copay<br>$105 copay for select insulins | $141 copay<br>$105 copay for select insulins | $141 copay<br>$105 copay for select insulins | $141 copay<br>$105 copay for select insulins |
| **Cost-Sharing Tier 4** (Non-Preferred Brand) | $300 copay<br>$105 copay for select insulins | $300 copay<br>$105 copay for select insulins | $300 copay<br>$105 copay for select insulins | $300 copay<br>$105 copay for select insulins |
| **Cost-Sharing Tier 5** (Specialty Tier) | A long-term supply is not available for drugs in Tier 5. | | | |

## Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,660

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$4,660 limit for the Initial Coverage Stage.**

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties

have spent on your behalf during the year. Many people do not reach the $4,660 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

## SECTION 6 Costs in the Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay, and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

Vantage STANDARD (HMO-POS) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a one-month supply. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by "SI" listed in the Drug List. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet). You also receive some coverage for generic drugs. You pay a) $0 copayment for a 31-day or 100-day supply of Preferred Generic drugs from preferred retail and mail order pharmacies, b) $5 copayment for a 31-day supply of Preferred Generic drugs from all other retail pharmacies, or c) 25% of the cost, whichever is lower, and the plan pays the rest. For all other generic drugs, you pay 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $7,400, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does not count toward your out-of-pocket costs (Section 1.3).

## SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs. You will pay:

- For Tier 1 Preferred Generic drugs filled at a:
    - preferred retail or mail order pharmacy, you pay a $0 copay

- standard retail or mail order pharmacy, you pay a $4.15 copay

- For all other covered drugs, your share of the cost will be either coinsurance or a copayment, whichever is the *larger* amount:
  - – *either* – coinsurance of 5% of the cost of the drug
  - – *or* – $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.
- **Our plan pays the rest** of the cost.

## SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

**Important Message About What You Pay for Vaccines -** Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist may give the vaccine in the pharmacy, or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D

benefit.

Below are three examples of ways you might get a Part D vaccine.

*Situation 1:* You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

*Situation 2:* You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

*Situation 3:* You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

# CHAPTER 7:

*Asking us to pay our share of a bill you have received for covered medical services or drugs*

## SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. **When you've received emergency or urgently needed medical care from a provider who is not in our plan's network**

   You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. **When a network provider sends you a bill you think you should not pay**

   Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

   - You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider

charges.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

**3. If you are retroactively enrolled in our plan**

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out of network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

## 7. When you pay out-of-pocket for dental, hearing or vision covered services

If you pay the full cost of eyewear, hearing or dental services, Vantage may reimburse you for certain covered services. If you forget to use your Vantage Flex card when purchasing eyewear from a participating retailer, please contact Member Services at (833) 952-2771 for help.

- Send us a copy of the bill, along with documentation of any payments you made, when you ask us to pay you back for our share of the cost. In some situations, we may need to get more information from you or your provider to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

You may request us to pay you back by either calling us or sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within six (6) months** of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster.

  Required information needed to make a decision:
  - Name of provider and specialty
  - Date of service
  - Item or service
  - Bill from provider
  - Paid receipts for item or service

- Either download a copy of the form from our website www.VantageMedicare.com or call Member Services and ask for the form.

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

**Payment Request Address**
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201

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

### Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

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

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

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

# CHAPTER 8:

*Your rights and responsibilities*

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in large print or other alternate formats at no cost if you need it. You may choose to enroll in Vantage's Digital Documents program. This program allows you to access your Vantage plan documents, including this *Evidence of Coverage*, via the Vantage website instead of traditional paper booklets. You can view Vantage documents at www.VantageMedicare.com, or download them from the website. You may also request copies of your documents by contacting Member Services at the phone number on the back cover of this booklet. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, please call to file a grievance with Member Services at 1-866-704-0109 (TTY users should call 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

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

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

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

### How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

### You can see the information in your records and know how it has been shared with others

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

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

If you have questions or concerns about the privacy of your personal health information, please call

Member Services.

**NOTICE OF PRIVACY PRACTICES FOR VANTAGE HEALTH PLAN**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.**

At Vantage Health Plan (Vantage), we respect the confidentiality of your health information and will protect it in a responsible and professional manner. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure.

This Notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information. We are allowed by law to use and disclose your health information to carry out the operations of our business. We are required by law to maintain the privacy of your health information, to provide you with this Notice, and abide by the Notice in effect. This Notice also informs you of your rights with respect to your health information and how you can exercise those rights.

**What is Protected Health Information or PHI?**
When we talk about "information" or "health information" in this Notice we mean Protected Health Information or PHI. PHI is any information, including genetic information, which identifies an individual enrolled in our Plan.

It relates to the person's participation in the Plan, the person's past, present or future physical or mental health or condition, the provision of health care to that person, or the past, present or future payment for the provision of health care to that person. PHI also includes information which identifies the person or for which there is a reasonable basis to believe it could be used to identify the person. This information includes many common identifiers (e.g., name, address, birth date, social security number). It does not include publicly available information, or information that is available or reported in a summarized fashion that does not identify any individual person.

**What types of personal information do we collect?**
Like all health benefits companies, we collect the following types of information about you:

- Information we receive directly or indirectly from you or your employer through applications, surveys, or other forms, in writing, in person, by telephone, or electronically, including our website (e.g., name, address, social security number, date of birth, marital status, dependent information, employment information, medical history).
- Information about your relationship and transactions with us, our affiliates, our providers, our agents, and others (e.g., health care claims and encounters, medical history, eligibility information, payment information, service request, and appeal and grievance information).
- Information we receive from the Centers for Medicare & Medicaid Services (CMS) and other authorized federal and state regulatory agencies.

**How do we protect this information?**
We have policies that limit internal and external sharing of PHI to only those persons who have a need for

it to provide benefit services to you and your dependents. We maintain physical, electronic, and procedural safeguards to protect PHI against unauthorized access and use. For example, access to our facilities is limited to authorized personnel and we protect information electronically through a variety of technical tools. We also have established a Privacy Committee, which has overall responsibility for the development, implementation, training, oversight and enforcement of policies and procedures to safeguard PHI against inappropriate access, use and disclosure, consistent with applicable law. If there is a reportable breach of unsecured PHI, we will notify you.

**How may we use or share your information?**
To effectively operate your health benefit plan, we may use and share PHI about you to:

- Perform certain duties, which may involve claims review and payment or denial; coordination of benefits; utilization review; medical necessity review; coordination of care; response to member inquiries or requests for services; conduct of grievance, appeals, and external review programs; benefits and program analysis and reporting; risk management; detection and investigation of fraud and other unlawful conduct; auditing; underwriting as permitted by law (genetic information may not be used or disclosed for underwriting purposes); administration and coordination of reinsurance contracts.
- Operate preventive health programs, early disease detection programs, disease management programs and case management programs in which we or our affiliates or contractors send educational materials and screening reminders to eligible members and providers; perform health risk assessments; identify and contact members who may benefit from participation in disease or case management programs; and send relevant information to those members who enroll in the programs, and their providers.
- Conduct quality improvement activities, such as the credentialing of participating network providers; and accreditation by the National Committee for Quality Assurance (NCQA), Medicaid, CMS, and/or other independent organizations, where applicable.
- Conduct performance measurement and outcomes assessment; health claims analysis and reporting.
- Provide data to outside contractors who help us conduct our business operations. **We will not share your PHI with these outside contractors unless they agree in writing to keep it protected.**
- Manage data and information systems.
- Perform mandatory licensing, regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration, or similar dispute resolution proceedings; and performing third-party liability and subrogation activities.
- Change policies or contracts from and to other insurers, HMOs, or third party administrators with compliant business associate agreements.
- Provide data to the employer or group that sponsors the benefit plan through which you receive health benefits. **We will not share your PHI with your benefit plan sponsor except for de-identified summary health information, enrollment and disenrollment information, specific information authorized by you, and any information necessary to administer the Plan.** De-identified means PHI

that does not identify an individual and there is no reasonable basis to believe that the information could be used to identify an individual.

We consider the activities described above as essential for the operation of our Plan. For example, we may feature:

- Cancer screening reminder programs that promote early detection of breast, ovarian, and colorectal cancer, when these illnesses are most treatable.
- Disease management programs that help members work with their physicians and other providers to effectively manage chronic conditions like asthma, diabetes, and heart disease to improve quality of life and avoid preventable emergencies and hospitalizations.
- Quality assessment programs that help us review and improve the services we provide.
- Outreach programs that help us educate members about the programs and services that are available to them, and let members know how they can make the most of their health benefits.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information as follows:

- To state and federal agencies that regulate us such as the US Department of Health and Human Services, the Department of Insurance for the state in which your insurance was sold, and CMS.
- For public health activities, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device issues or problems.
- To public health agencies if we believe there is a serious health or safety threat.
- To a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions.)
- To a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
- For law enforcement purposes, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To a government authority regarding child abuse, neglect or domestic violence.
- To a coroner or medical examiner to identify a deceased person, determine a cause of death, or as otherwise authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- For procurement, banking or transplantation of organs, eyes or tissue.
- To specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and other government officials.

- For on-the-job-related injuries because of requirements of state workers' compensation laws.

We do not share PHI for any purpose other than those listed above. If one of the above reasons does not apply, **we must obtain your written authorization to use or disclose your health information**. For example, written authorization from you would be required for the use and/or disclosure of psychotherapy notes (if applicable) and the use of PHI for marketing purposes. Written authorization is also required for the "sale" of PHI as defined under 45CFR Section 164.502. In the event that you are unable to provide the authorization (for example, if you are medically unable to give consent), we will accept authorization from any person legally authorized to give consent on your behalf, such as a parent, guardian, or court-appointed representative. If you give us written authorization and change your mind, you may revoke your written authorization at any time.

**What are your rights?**
The following are your rights with respect to your PHI. If you would like to exercise any of these rights, please contact us at the address or phone numbers listed at the end of this Notice. We will require that you make your request in writing and will provide you with the appropriate forms.

**You have the right to inspect and/or obtain a copy or summary of information** that we maintain about you in your designated record set. A "designated record set" is a group of records maintained by or for us that are your enrollment, payment, claims determination, and case or medical management records or a group of records, used in whole or in part, by us to make decisions about you, such as appeals and grievance records. We may charge you a reasonable administrative fee for copying, postage or summary preparation depending on your specific request.

However, you do not have the right to inspect certain types of information and we cannot provide you with copies of information:

- contained in psychotherapy notes; or
- compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding.

We will do our best to respond to your request for information no later than thirty (30) days after we receive it. If, however, we are unable to fulfill your request within this 30-day period, we may extend the period to respond by an additional 30 days provided we have given you a timely explanation for the delay.

Additionally, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

**You have the right to ask us to amend information** we maintain about you in your designated record set. We will require that your request be in writing. We will respond to your request no later than 30 days after we receive it. If we are unable to act within 30 days, we may extend that time by no more than an additional 30 days. If we need the extension, we will notify you of the delay, the reason for the delay, and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the

amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to dispute your statement through a written rebuttal. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures.

**NOTE:** If you want to access or amend information about yourself, you should first go to your provider (e.g., physician, pharmacy, hospital or other caregiver) that generated the original records, which could be more complete than any we maintain.

**You have the right to receive an accounting of certain disclosures** of your information made by us during the six (6) years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected prior to April 14, 2003.
- Information disclosed or used for treatment, payment, and health care operations purposes.
- Information disclosed to you or pursuant to your authorization;
- Information that is incident to a use or disclosure otherwise permitted.
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies;
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We will act on your request for an accounting within 30 days. If we need additional time to act on your request, we may take up to an additional 30 days. In connection therewith, we will provide you with a written statement of the reasons for the delay and the date by which we will provide the accounting. Your first accounting will be at no cost, and we will continue to provide to you one free accounting upon request every twelve (12) months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. The fee will be reasonable and cost-based. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

**You have the right to ask us to restrict** how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. If we engage in any type of fundraising activity, you have the right to opt out of receiving any such

communication.

**You have the right to ask to receive confidential communications** of information. We may require that your request include a statement that disclosure of all or part of the information to which the request pertains could endanger you or someone else. For example, in situations involving domestic disputes or violence, you can ask us to send the information by alternative means (for example by fax) or to an alternative address. We will try to accommodate any reasonable request made by you.

**What do we do with member PHI when the member is no longer enrolled in our Plan?**
We do not destroy PHI when individuals terminate their coverage. The information is necessary and used for many purposes as described in this Notice, even after the individual leaves a Plan. However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual member. In many cases, PHI is subject to legal retention requirements, and after that requirement for record maintenance, PHI is destroyed in a secure process.

**Exercising your rights:**

- **You have a right to receive a copy of this Notice upon request at any time.** We provide this Notice to our subscribers upon enrollment in a Vantage health plan. You can also view a copy of the Notice on our website at www.VantageMedicare.com. Should any of our privacy practices change, **we reserve the right to change the terms of this Notice and to make the new Notice effective for all protected health information that we maintain**. Once revised, we will provide the new Notice to you and post it on our website.
- If you have any questions about this Notice or about how we use or share information, please write to the Vantage Privacy Officer at 130 DeSiard Street, Suite 300, Monroe, LA 71201 or email **Privacy.Office@vhpla.com**. Or you can contact our Member Services Department at the phone numbers listed on the front cover.

If you are concerned that your privacy rights may have been violated, you may file a complaint with us. You also have the right to complain directly to the Secretary of the U.S. Department of Health and Human Services. If you have any questions about the complaint process, including the address of the Secretary of Health and Human Services, please write to our Privacy Officer at the address mentioned above or contact our Member Services Department (phone numbers are on the cover of this booklet).

**Vantage will not take any action against you for filing a complaint.**

## Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Vantage STANDARD (HMO-POS), you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition.

- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

### You have the right to know your treatment options and participate in decisions about your health care

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

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

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

### You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance of these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

**Louisiana Department of Health & Hospitals**

*Physical address:*
628 N. 4th Street
Baton Rouge, LA 70802

*Mailing address:*
P.O. Box 629
Baton Rouge, LA 70821-0629

Phone: 1-225-342-9500 TTY: 711

Fax: 1-225-342-5568

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

At Vantage, a process called Utilization Management (UM) is used to determine whether a service or treatment is covered and appropriate for payment under your benefit plan. Vantage does not reward or provide financial incentives to doctors, other individuals, or Vantage employees for denying coverage or encouraging underuse of services. In fact, Vantage works with your doctors and other providers to help you get the most appropriate care for your medical condition. If you have questions or concerns related to Utilization Management, staff are available at least eight hours a day during normal business hours.

Vantage has developed a medical policy for the purpose of providing guidelines for determining coverage criteria for specific recently developed and/or practiced medical and behavioral health care technologies, including procedures, equipment, pharmaceuticals, devices, and services. In order to be eligible for coverage, all services must be medically necessary. To the extent there are any conflicts between Vantage's medical policy guidelines and this Plan's language, the Plan's language prevails.

Issues are selected for medical policy development through referrals from Vantage staff, the Provider community, and Members. The technology assessment process is applied to both the development of new medical policies and updates to existing medical policies. In order to determine whether a medical technology may be considered medically necessary, literature searches are conducted and the published scientific evidence related to each technology is reviewed against five technology assessment criteria. In order for a technology to be considered medically necessary, all five criteria must be met:

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

Vantage medical policies are submitted for review to Vantage Medical Directors. Upon review, the Medical Directors will engage external practicing physicians and specialists in the Vantage Service Area based on the areas of technology being evaluated and/or the specific medical discipline. Additional external resources may be utilized according to the complexity of the technology being evaluated. Opinions from these external sources will be compiled along with scientific evidence and the Medical Director summaries for the final approval process.

All policy drafts, including analyses of the scientific evidence and summaries of the external expert opinion, are presented to the Vantage Utilization Management Committee for final approval and implementation.

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal,

Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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

### If it is about discrimination, call the Office for Civil Rights

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

### Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

## Section 1.8 How to get more information about your rights

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

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to

follow to get your covered services.

  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

# CHAPTER 9:

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

# SECTION 1 Introduction

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

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

## Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

# SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

### State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you

more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

### Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

## SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

**Is your problem or concern about your benefits or coverage?**

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

**Yes.**

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

**No**.

Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

# COVERAGE DECISIONS AND APPEALS

## SECTION 4 A guide to the basics of coverage decisions and appeals

### Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical

services and prescription drugs, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

### Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

### Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able

to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

## Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

## Section 4.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your SHIP.

# SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

## Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

   **Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

## Section 5.2 Step-by-step: How to ask for a coverage decision

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

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

**A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:**

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

***For standard coverage decisions we use the standard deadlines.***

**This means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

***For Fast Coverage decisions we use an expedited timeframe***

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

- **However,** if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

## Section 5.3 Step-by-step: How to make a Level 1 appeal

| Legal Terms |
|---|
| An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**<br><br>A "fast appeal" is also called an **"expedited reconsideration."** |

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

**A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.**

- If you are appealing a decision, we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

## Step 2: Ask our plan for an appeal or a Fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed possibly contacting you or your doctor.

***Deadlines for a "fast appeal"***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the

appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

***Deadlines for a "standard appeal"***

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

## Section 5.4 Step-by-step: How a Level 2 appeal is done

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

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

### Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

***If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2***

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

***If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2***

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

### Step 2: The independent review organization gives you their answer.

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

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your

request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision
- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

### Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

## Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

### Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

**To make this appeal, follow the process for appeals that we describe in Section 5.3**. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

## SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

### Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only**. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or "Formulary."

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

#### Part D coverage decisions and appeals

| Legal Term |
|---|
| An initial coverage decision about your Part D drugs is called a **"coverage determination."** |

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs.* **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**

- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

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

## Section 6.2 What is an exception?

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

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

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

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 5. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier cost that contains biological product

alternatives for treating your condition.

- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 - Specialty Tier.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

## Section 6.3 Important things to know about asking for exceptions

### Your doctor must tell us the medical reasons

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

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

### We can say yes or no to your request

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

## Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

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

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

**"Standard coverage decisions"** are made within **72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

***If your health requires it, ask us to give you a "fast coverage decision."*** **To get a fast coverage decision, you must meet two requirements:**

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

### Step 2: Request a "standard coverage decision" or a "fast coverage decision."

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which are available on our website. Chapter 2 has contact information.

- Members can submit coverage determination requests electronically through this link on the website (www.VantageHealthPlan.com/VantageMedicare/CoverageRedeterminationRequestForm). Fill out the Coverage Determination Request Form. You will need to send us supporting documentation from the prescribing doctor to show medical need. Your information will be sent to us securely. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

your representative.

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

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

***Deadlines for a "fast" coverage decision***

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a "standard coverage decision" about a drug you have not yet received***

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer within **14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment

to you within 14 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

## Section 6.5 Step-by-step: How to make a Level 1 appeal

| Legal Terms |
|---|
| An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**<br>A "fast appeal" is also called an **"expedited redetermination."** |

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

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

- If you are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

### Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request**. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 1-866-704-0109. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- Members can submit appeal requests electronically through this link on our website (www.VantageHealthPlan.com/VantageMedicare/CoverageRedeterminationRequestForm). Fill out the Coverage Redetermination Request Form. You will need to send us supporting documentation from the prescribing doctor to show medical need. Your information will be sent to us securely.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

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

***Deadlines for a "fast appeal"***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a "standard appeal" for a drug you have not yet received***

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a "standard appeal" about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

## Section 6.6 Step-by-step: How to make a Level 2 appeal

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

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

### Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

### Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information

related to your appeal.

***Deadlines for "fast appeal"***

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

***Deadlines for "standard appeal"***

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

### Step 3: The independent review organization gives you their answer.

***For "fast appeals":***

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

***For "standard appeals":***

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

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

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

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

**your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

### Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your

discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

## Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

### Step 1: Contact the Quality Improvement Organization for your state and ask for an

**immediate review of your hospital discharge. You must act quickly.**

***How can you contact this organization?***

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

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

***What happens if the answer is yes?***

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

***What happens if the answer is no?***

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

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

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

## Section 7.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

### Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the

**reviewers will decide on your appeal and tell you their decision.**

***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

***If the review organization says no:***

- It means they agree with the decision they made on your Level 1 appeal. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

### Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## Section 7.4 What if you miss the deadline for making your Level 1 appeal?

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

### You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different*.

### Step-by-Step: How to make a Level 1 *Alternate* appeal

### Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast"

deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

### Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

### Step 3: We give you our decision within 72 hours after you ask for a "fast review."

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

### Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

### Step-by-Step: Level 2 *Alternate* appeal Process

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

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

### Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

### Step 2: The independent review organization does a "fast review" of your appeal. The

**reviewers give you an answer within 72 hours.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

### Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

### Section 8.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost 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 8.2 We will tell you in advance when your coverage will be ending

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.
- How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

## Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

### <u>Step 1:</u> Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

***How can you contact this organization?***

- The written notice you received (*Notice of Medicare Non*-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

***Act quickly:***

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

***Your deadline for contacting this organization.***

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

| Legal Term |
|---|
| "**Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage. |

***What happens during this review?***

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

### Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

***What happens if the reviewers say yes?***

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

***What happens if the reviewers say no?***

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

## Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

### Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

***What happens if the review organization says yes?***

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

***What happens if the review organization says no?***

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled

by an Administrative Law Judge or attorney adjudicator.

### Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## Section 8.5 What if you miss the deadline for making your Level 1 appeal?

### You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

### Step-by-Step: How to make a Level 1 *Alternate* appeal

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

### Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

### Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

### Step 3: We give you our decision within 72 hours after you ask for a "fast review"

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not

pay any share of the costs after this date.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

### Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

### Step-by-Step: Level 2 *Alternate* appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

### Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

### Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

### Step 3: If the independent review organization says no to your appeal, you choose

**whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## SECTION 9 Taking your appeal to Level 3 and beyond

### Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

| | |
|---|---|
| **Level 3 appeal** | **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer. |

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal** The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

**Level 5 appeal** A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 appeal** **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

| | |
|---|---|
| **Level 4 appeal** | The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government. |

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

| | |
|---|---|
| **Level 5 appeal** | A judge at the **Federal District Court** will review your appeal. |

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## MAKING COMPLAINTS

## SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

### Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

| Complaint | Example |
|---|---|
| **Quality of your medical care** | • Are you unhappy with the quality of the care you have received (including care in the hospital)? |

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

## Section 10.2 How to make a complaint

| Legal Terms |
|---|
| • A **"Complaint"** is also called a **"grievance."**<br>• **"Making a complaint"** is also called **"filing a grievance."**<br>• "**Using the process for complaints"** is also called "**using the process for filing a grievance."**<br>• A **"fast complaint"** is also called an **"expedited grievance."** |

## Section 10.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **A grievance (complaint) may be filed by submitting the completed details in writing to Vantage Health Plan at the following location: ATTN: Medical Director, 130 DeSiard Street, Suite 300, Monroe, LA 71201**. The grievance must be submitted within sixty (60) days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than thirty (30) days after receiving your complaint. You have the right to file an expedited grievance whenever we deny your request for an expedited decision about your request for a service, or, whenever we deny your request for an expedited decision about your appeal for a service. You also have the right to file an expedited grievance if you do not agree with our decision to extend the time needed to make a decision on your request for a service, or to consider your appeal for a service. We must decide within twenty-four (24) hours if our decision to deny or delay making an expedited decision puts your life or health at risk. We may extend the timeframe for deciding on a grievance by up to fourteen (14) days if you ask for the extension, or are justified in request additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it and will tell you about any dispute resolution options you may have.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

### Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

## Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care,* you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

*Or*

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

## Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about Vantage STANDARD (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

# CHAPTER 10:

*Ending your membership in the plan*

## SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Vantage STANDARD (HMO-POS) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Section 2 and Section 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

### Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

### Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period.**

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

## Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Vantage STANDARD (HMO-POS) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Louisiana Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

**Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

**The enrollment time periods vary** depending on your situation.

**To find out if you are eligible for a Special Enrollment Period,** please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- *– or –* Original Medicare *without* a separate Medicare prescription drug plan.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

**Your membership will usually end** on the first day of the month after your request to change your plan is received.

**If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

### Section 2.4 Where can you get more information about when you can end your membership?

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

- Call Member Services.
- You can find the information in the ***Medicare & You 2023*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

| If you would like to switch from our plan to: | This is what you should do: |
|---|---|
| • Another Medicare health plan. | • Enroll in the new Medicare health plan.<br>• You will automatically be disenrolled from Vantage STANDARD (HMO-POS) when your new plan's coverage begins. |
| • Original Medicare *with* a separate Medicare prescription drug plan. | • Enroll in the new Medicare prescription drug plan.<br>You will automatically be disenrolled from Vantage STANDARD (HMO-POS) when your new plan's coverage begins. |

| If you would like to switch from our plan to: | This is what you should do: |
|---|---|
| • Original Medicare *without* a separate Medicare prescription drug plan. | • **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this.<br>• You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.<br>• You will be disenrolled from Vantage STANDARD (HMO-POS) when your coverage in Original Medicare begins. |

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

## SECTION 5 Vantage STANDARD (HMO-POS) must end your membership in the plan in certain situations

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

**Vantage STANDARD (HMO-POS) must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you 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, call Member Services to find out if the place you are moving or traveling to is in our plan's area.

- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premium for 60 days.
    - We must notify you in writing that you have 60 days to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

### Where can you get more information?

If you have questions or would like more information on when we can end your membership call Member Services.

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

Vantage STANDARD (HMO-POS) is not allowed to ask you to leave our plan for any health-related reason.

### What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

end your membership.

# CHAPTER 11:

*Legal notices*

## SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

## SECTION 2 Notice about nondiscrimination

**We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

## SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Vantage STANDARD (HMO-POS), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

## SECTION 4 Notice about communications

The member will be notified by our plan of coverage termination at his/her last known address. The member is responsible for the cost of all benefits which are provided after the date of termination of coverage. Our plan will not be liable for loss of notices, communications or materials sent by our plan to members when such notices, communications or materials are properly addressed to the member's last

known address, as provided to our plan.

## SECTION 5 Notice about affirmative statement

Our plan does not reward or compensate Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals that are involved in Utilization Review decisions for denials, does not offer incentives to encourage denials, and does not encourage decisions that may result in underutilization. Our plan ensures independence and impartiality in making referral decisions and attests that involvement will not influence compensation, hiring, termination, promotion or any other similar matters for the Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions in the Utilization Review process based upon the likelihood or perceived likelihood that the Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions will support or tend to support the denial of benefits.

## SECTION 6 Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1. Our payments are less than the recovery amount. If our payments are less than the total recovery amount from any third party (the “recovery amount”), then our reimbursement is computed as follows:
    a. Determine the ratio of the procurement costs to the recovery amount (the term “procurement costs” means the attorney fees incurred in obtaining a settlement or judgment).
    b. Apply the ratio calculated above to our payment. The result is our share of procurement costs.
    c. Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2. Our payments equal or exceed the recovery amount. If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3. We incur procurement costs because of opposition to our reimbursement. If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
    a. Our payments made on your behalf for services; or
    b. the recovery amount, minus the party’s total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and

you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

## SECTION 7 Member liability

In the event we fail to reimburse network provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for those services except for the following eligible expenses:

- Emergency services
- Urgently needed services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a provider, neither the plan nor Medicare will pay for those services.

## SECTION 8 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    2. Furnished in a setting appropriate to the patient's medical needs and condition;
    3. Ordered and furnished by qualified personnel;
    4. One that meets, but does not exceed, the patient's medical need; and
    5. At least as beneficial as an existing and available medically appropriate alternative.

## SECTION 9 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of automobile, accident or other liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to

notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under state and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.

## SECTION 10 Acts beyond our control

If, due to a natural disaster, pandemic, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

## SECTION 11 Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships.

## SECTION 12 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions. In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our medical directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

## SECTION 13 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs

## SECTION 14 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud?

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we are asking for your help. If you identify a potential case of fraud, please report it to us immediately. Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, pharmacy, or medical device company - bills for services you never got;
- A supplier bills for equipment different from what you got;
- Someone uses another person’s Medicare card to get medical care, prescriptions, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that has not been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call our Fraud Hotline at 1-800-329-9249. (TTY users should call 711.) This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith. You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFE-RX (1-877-772-3379) or Original Medicare at 1-800-MEDICARE (1-800-633-4227).

# CHAPTER 12:

*Definitions of important words*

**Affinity Health Network (AHN)** – Network providers with lower cost share than the plan's standard network providers for certain specified medical services and certain mail order prescription drugs as stated in Chapters 4 and 6.

**Allowed Amount** – The amount the plan would pay (before applicable deductibles, copayments, or coinsurance) to a provider for rendering a covered service/drug.

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

**Annual Enrollment Period** – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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

**Balance Billing** – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Vantage STANDARD (HMO-POS), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan from network providers, unless the service is not a Medicare-covered service (such as dental, vision, and hearing). We do not allow network providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

**Benefit Period** – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. Our plan also has a benefit period for skilled nursing facility benefits. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any inpatient skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. For inpatient hospital care, the Medicare-defined benefit period does not apply to this plan. The cost-sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted into the hospital.

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

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,400 in covered drugs during the covered year.

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

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

**Complaint** - The formal name for "making a complaint" is "filing a grievance." The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or "copay")** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

**Cost-Sharing** – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

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

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

**Coverage Gap Stage –** Sometimes called the "donut hole." This means that after you and your plan have spent a certain amount of money for covered drugs, the plan does not provide coverage for your brand drugs or for your generic drugs (except for Tier 1 Preferred Generics and Select Insulins) until your year-to-date out-of-pocket costs reach $7,400 and you enter the Catastrophic Coverage Stage. See Chapter 6, Section 6 for more information on the Coverage Gap Stage.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by

people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

**Daily cost-sharing rate** – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $31, and a one-month's supply in your plan is 31 days, then your "daily cost-sharing rate" is $1 per day.

**Deductible** – The amount you must pay for health care from out-of-network providers or for certain prescription drugs before our plan pays.

**Deemed Eligible Individual –** An individual who is deemed as meeting the eligibility requirement for full subsidy eligible individuals if the individual is entitled to Medicare and is a full benefit dual eligible individual (eligible for full Medicaid benefits); a recipient of Supplemental Security Income (SSI) benefits; or eligible for full Medicaid benefits, and/or the Medicare Savings Program as a Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI) under a State's Medicaid plan.

**Disenroll or Disenrollment** – The process of ending your membership in our plan.

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

**Dual Eligible Individual –** A person who qualifies for Medicare and Louisiana Medicaid coverage.

**Dual Eligible Special Needs Plans (D-SNP)** – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

**Emergency Care** – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

**Grievance** - A type of complaint you make about our plan, network providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

**Home Health Aide** – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Home Health Care -** Skilled nursing care, physical therapy, speech therapy, and continued occupational therapy are covered services for treatment of an illness or injury, in your home, if the following conditions are met: (1) your doctor has determined the need for skilled care at home and has outlined the plan of care, (2) you must be home-bound, and (3) you receive care from a Medicare-certified home health agency. Home health aide services are covered, if ordered by your physician, within the plan of care. Home health aide services must be reasonable and necessary to the treatment of the patient's illness or injury, and must coordinate with other skilled services. All home health services are for part-time, or "intermittent" care only and do not include housekeeping, food service, or full-time nursing care.

**Hospice -** A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

**Hospice Care** – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. Hospice care is covered by Original Medicare and not by Vantage STANDARD (HMO-POS).

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

**Income Related Monthly Adjustment Amount (IRMAA)** – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people

will not pay a higher premium.

**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage –** This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $4,660.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Lifetime Reserve Days –** In the Original Medicare Plan and our plan, a total of 60 extra days that Medicare or our plan will pay for when you are in a hospital more than 90 days. Once these 60 reserve days are used, you do not get any extra days during your lifetime.

**List of Covered Drugs (Formulary or "Drug List")** – A list of prescription drugs covered by the plan.

**Low Income Subsidy (LIS)** – See "Extra Help."

**Maximum Charge** – This is the most that a member will have to pay for services received from a provider.

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, prescription drugs, all Point-of-Service benefits, and all non-Medicare-covered services do not count toward the maximum out-of-pocket amount. There is no maximum out-of-pocket for out-of-network (POS) services.

**Medicaid (or Medical Assistance)** – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medical Care -** Medical items and services as well as Medicare Part B prescription drugs.

**Medical Emergency –** See "Emergency."

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Open Enrollment Period** – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is

first eligible for Medicare.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, an ii) HMO-POS, a iii) PPO, a iv) Private Fee-for-Service (PFFS) plan, or a v) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**"Medigap" (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or "Plan Member")** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network** – A network consists of facilities, physicians, other healthcare professionals, pharmacies, and suppliers our plan has contracted with to provide health care services. See Chapter 1, Section 1.1 and Section 3.2 for information about networks.

**Network Pharmacy** – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider** – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. "**Network providers**" have an agreement with our plan to accept our payment as payment in

full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers." See also "Affinity Health Network" and "Standard Network" definitions.

**Organization Determination** – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

**Original Medicare** ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

**Out-of-Pocket Costs** – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

**Out-of-Pocket Maximum –** see "Maximum Out-of-Pocket Amount."

**PACE Plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Louisiana Medicaid benefits through the plan.

**Part C** – see "Medicare Advantage (MA) Plan."

**Part D** – The voluntary Medicare Prescription Drug Benefit Program.

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

**Part D Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

**Point-of-Service (POS)** – An HMO option that lets a member use out-of-network providers for an additional cost. See Chapter 1, Section 1.1 and Section 3.2 and Chapter 3, Section 2.4 for additional

information. This plan covers POS benefits up to a maximum of $5,000.

**Preferred Cost Sharing** – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at preferred retail and mail order pharmacies. See Chapter 5, Section 2.3 for additional information.

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

**Prescription Drug Benefit Manager** – An entity that provides pharmacy benefit management services, which may include contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; aiding in the development and management of formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary. All services obtained from out-of-network providers require prior authorization (except emergency services, supplemental dental services, supplemental vision services, supplemental hearing services, urgently needed care when the network is not available, and dialysis outside the plan's service area). This plan covers POS benefits up to a maximum of $5,000.

**Prosthetics and Orthotics** – Medical devices including, 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 practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Enrollment Period** – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you

move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

**Standard Cost Sharing –** Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

**Standard Network** – Vantage network providers other than the Affinity Health Network providers.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**Subrogation –** Subrogation means Vantage can regain by legal action, if necessary, the cost of benefits paid by Vantage from any person or entity against whom the member may have a claim.

**Supplemental Security Income (SSI)** – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Services** – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

# Addendum to the Vantage STANDARD (HMO-POS) 2023 Annual Notice of Changes (ANOC), Evidence of Coverage (EOC), and Summary of Benefits

**This addendum includes important information on changes in your Vantage STANDARD (HMO-POS) coverage.** Due to the Inflation Reduction Act, cost-sharing amounts could change for Part B drugs and insulin. Please keep this information for your reference.

Beginning April 1, 2023, the member's coinsurance may change quarterly, based on the Centers for Medicare and Medicaid Services (CMS)-defined list of chemotherapy/radiation drugs and other Part B prescription drugs (also known as "rebatable drugs"). The coinsurance paid for these rebatable drugs, which include Part B chemotherapy administration services, will be reduced if the drug's price has increased at a faster rate than the rate of inflation. CMS determines the rebatable drugs, their allowed amounts and the coinsurance due; however, the coinsurance amount cannot exceed the Original Medicare adjusted coinsurance amount of 0-20%. CMS may update the list of rebatable drugs and their costs quarterly.

Beginning July 1, 2023, Part B insulin furnished through an item of durable medical equipment will be covered at or below the cost share cap of $35 for a one-month's supply and will not be subject to a deductible. This coverage is similar to your existing Part D insulin coverage.

This addendum will be attached to the ANOC, EOC, and Summary of Benefits on our website at www.VantageMedicare.com. You are not required to take any action in response to this document, but we recommend you keep this information for future reference. If you have any questions, please call us at 1-866-704-0109. (TTY users should call 711.) Member Services will operate seven (7) days a week from 8:00 a.m. – 8 p.m. CST from October 1, 2022 – March 31, 2023. After March 31, 2023, Member Services will operate five (5) days a week, Monday – Friday, 8:00 a.m. – 8:00 p.m. CST.

*Sincerely,*

*Member Services*

Vantage Health Plan (Vantage) is an HMO with a Medicare contract. Enrollment in Vantage depends on contract renewal.

# NONDISCRIMINATION NOTICE

Vantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic. Vantage does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic.

Vantage provides free aids and services to people with disabilities to communicate effectively with us. Those services include qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats).

For people whose primary language is not English, Vantage provides free language translation services. Those services include qualified interpreters and information written in other languages. You can use Vantage's free language translation services by calling the "Members" phone number on the back of your Member ID card. For Members who are deaf or hearing impaired, please call for teletypewriter (TTY) services at 711.

If you believe that Vantage has failed to provide these services or has discriminated in another way on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic, you can file a grievance with Vantage or the U.S. Dept. of Health and Human Services, Office for Civil Rights.

If you would like to file a complaint directly with Vantage, you can reach us in person, by mail, by fax, or by email at the addresses below:

Vantage Health Plan
Attention: Civil Rights Coordinator
130 DeSiard Street, Suite 300
Monroe, LA 71201
Phone: (318) 998-2887, TTY 711
Fax: (318) 361-2165
Email: civilrightscoordinator@vhpla.com

If you would like to file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights, you can contact them by mail, by phone, or by email at the addresses below:

U.S. Department of Health and Human Services
200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Online Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby. jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. If you need help filing a grievance, our Civil Rights Coordinator is available to help at civilrightscoordinator@vhpla.com or by phone at (318) 998-2887.

Vantage has adopted internal grievance procedures for providing prompt and equitable resolution of complaints alleging discrimination on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic. Any person who believes someone has been subjected to discrimination on any of these grounds, may file a grievance under Vantage's grievance procedure. Itis against the law for Vantage to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Depending on the type of grievance, a 60-day filing limit may apply. To learn more about Vantage's grievance procedure, you can call or email our Civil Rights Coordinator at the addresses above or you can visit our website at www.vantagehealthplan.com/vhpnondiscriminationgrievanceprocedure.

*Vantage Health Plan is required by federal law to provide the following information.*

MULTI-LANGUAGE INSERT
MULTI-LANGUAGE INTERPRETER SERVICES

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 888-823-1910 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 888-823-1910 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 888-823-1910 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 888-823-1910 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 888-823-1910 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 888-823-1910 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 888-823-1910 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 888-823-1910 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 888-823-1910 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 888-823-1910 (TTY 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 888-823-1910 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 888-823-1910 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 888-823-1910 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 888-823-1910 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 888-823-1910 (TTY 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、888-823-1910 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。 これは無料のサー ビスです。

**Choctaw:** Chishnoat yvmmakosh chi apelaachih, hachishnovt ponaklo pilah Vantage Health Plan achih, chi ishtimpakvt chi nokfokah annopa chim annopoli keyo tvli holissoh ishahlih. Yvmma-kosh annopoli tosholi, makachi telefon 888-823-1910 (TTY 711).

**Laotian:** ພວກເຮົາມີບໍລິການແປພາສາຟຣີເພື່ອຕອບຄຳຖາມໃດໆທີ່ທ່ານອາດມີກ່ຽວກັບແຜນສຸຂະພາບຫຼືຢາຂອງພວກເຮົາ. ເພື່ອຮັບຜູ້ແປພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ 888-823-1910 (TTY 711). ຄົນທີ່ເວົ້າພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

**Persian:** ما خدمات مترجم رایگان برای پاسخ به هر گونه سوال شما ممکن است در مورد سلامت ما و یا طرح مواد مخدر داشته باشد. برای دریافت مترجم، فقط با ما در 888-823-1910 (TTY 711) به فارسی صحبت می کند می تواند که کسی .تماس بگیرید .این یک سرویس رایگان است .شما کمک کند

**Urdu:** ہمارے پاس ہماری صحت یا منشیات کے منصوبے کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لئے مفت ترجمان خدمات ہیں۔ ایک ترجمان حاصل کرنے کے لئے، صرف ہمیں 888-823-1910 )ٹی وائی 711 (پر کال کریں۔ جو کوئی اردو بولتا ہے وہ آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے.

*Vantage Health Plan is required by federal law to provide the following information.*

## Vantage Standard (HMO-POS) Member Services:

| Method | Member Services – Contact Information | |
|---|---|---|
| **CALL** | 318-361-0900<br><br>866-704-0109<br>Calls to this number are free. | Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. | |
| **FAX** | 318-361-2181 | |
| **WRITE** | 130 DeSiard Street, Suite 300, Monroe, LA 71201 | |
| **WEBSITE** | *www.VantageMedicare.com* | |

## Hours of Operation:

***October 1, 2022 through March 31, 2023:***
Seven (7) Days a Week 8:00 a.m. – 8:00 p.m.

***All other dates:***
Monday through Friday 8:00 a.m. – 8:00 p.m.

## Vantage Corporate Location:

***Monroe***
130 Desiard Street, Suite 300
Monroe, LA 71201

*For Information On Other Locations:*
***www.vantagehealthplan.com/locations***

**Senior Health Insurance Information Program (Louisiana SHIIP):**
The Louisiana SHIIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

**Phone Numbers**
225-342-5301 or toll- free 800-259-5300

**Website**
*www.ldi.la.gov/SHIIP*

**Mailing Address**
P.O. Box 94214
Baton Rouge, LA 70804

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